CLEARINGHOUSE

MEDICAID AND AFDC FRAUD AND ABUSE CONTROL AND RESTITUTION EFFORTS BY STATES AND LOCALITIES

"BEST PRACTICES" CASE STUDY: OHIO
MEDICAID PROGRAM

October 1976

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
HEALTH CARE FINANCING ADMINISTRATION
MEDICAID BUREAU

REPORTS
RA
412
.4
M4201
1976
Medicaid Ohio

RA
412.4
.M4201
1976
Medicaid
Ohio

CLEARINGHOUSE

"Best Practices" Case Study

Ohio Medicaid Program

A Descriptive Review of Exemplary Program Options

Prepared Under SRS Contract No. SRS-500-75-0004

by

General Research Corporation
Westgate Research Park
McLean, Virginia 22101

October 1976

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Health Care Financing Administration
Medicaid Bureau

For additional information concerning the procedures discussed in this report, contact:

Bertha Levy
Medical Units
Sequoyah Building
Oklahoma City, Oklahoma 73125

PREFACE

This report is one of a series of "best practices" case studies prepared by General Research Corporation and its subcontractor SysteMetrics under contract to the Office of Planning, Analysis and Evaluation, Social and Rehabilitation Service, Department of Health, Education and Welfare. These case studies are part of a larger effort by General Research Corporation and its subcontractor SysteMetrics to assist DHEW in the analysis of the fraud and abuse control activities nationwide in Medicaid and Aid to Families with Dependent Children programs. Other activities include a nationwide mail survey to collect baseline data on fraud and abuse control efforts in all states and an analysis of the options available to the Federal government to further enhance fraud and abuse control in these programs.

The "best practices" case studies are based on visits made by GRC/SysteMetrics staff to selected states which appeared to constitute the best examples of fraud and abuse control programs. The primary objective of this effort is to determine what procedures and practices that the selected states are using appear to be effective and worthy of replication in other jurisdictions. Each state is individually reported in this case study format and from this data base a final analytic report discussing the relative value of the exemplary practices seen in all states will be prepared. The states to be reported in this series include:

Medicaid	AFDC
California	Maryland
Maryland	Massachusetts
Massachusetts	Michigan
Michigan	Minnesota
New Jersey	New Jersey
Ohio	Ohio
Oklahoma	Pennsylvania
Pennsylvania	Washington
Washington	Wisconsin

The states were selected in conjunction with DHEW personnel and represent those states which appeared to represent a mix of practices of interest to the study and which were suitable for site visits at the time of the study. Therefore, these do not necessarily represent the "best" nine states with respect to fraud and abuse control in each program but are certainly among the best.

Fraud and abuse control is an integral part of maintaining program integrity and increasing the quality and efficiency with which the program is administered and program goals are achieved. It is essential that fraud and abuse control procedures not be viewed in isolation from other program elements, but should be recognized as being part of a series of steps which states can take to improve the operation of their programs and reduce costs incurred through the misappropriation of program funds. Therefore, in the course of conducting this study and in developing the case study reports, fraud and abuse control efforts have been defined to include all systems and procedures which impact fraud and abuse prevention, detection, investigation, administrative actions, prosecutions and recovery. The case studies are organized to report each state's activities in these functional areas in the initial chapters. The authors' opinions and analysis have been reserved for the final chapter on best practices. The best practices chapter is designed to discuss conceptually how and why procedures reported in the initial chapters are exemplary and may be suitable for replication in other jurisdictions. Therefore, the best practices chapter discusses the pros and cons of such practices in various settings and is not directly a comment on the state reported, but rather an analysis of the practice per se and how the reported state exemplifies the concept.

Finally, these reports are in no way intended to be evaluations of the states involved and General Research Corporation is deeply indebted to the states which so graciously participated and assisted in these studies through the contribution of their time, information, and ideas.

TABLE OF CONTENTS

		PAGE
PREFACE		i
I.	PROGRAM OVERVIEW	1
	A. History	1
	B. Program Characteristics	1
II.	PROVIDER FRAUD AND ABUSE CONTROL PROGRAM	6
	A. Administration	6
	B. Prevention	7
	C. Detection	
	D. Investigation	16
	E. Outcomes	21
	F. Program Assessment	28
III.	RECIPIENT FRAUD AND ABUSE CONTROL PROGRAM	
	A. General Description	32
	B. Misutilization of Services	32
IV.	AGENCY FRAUD AND ABUSE CONTROL	36
V.	BEST PRACTICES	37
	A. Introduction	37
	B. The Ohio Medicaid Management Information	38
	C. Project Approach to Surveillance and Utilization Review	43
	D. Outside State Agency with Independent Authority	45
	E. Third Party Recoveries	47
APPENDIXES		
I.	Methods and Standards for Establishing Payment Rates	51
II.	Prepayment Checks	61
III.	MMIS Reports	72
IV.	Sample MMIS Summary Report	75
V.	Sample Study Project Plan	81
VI.	Hospital Field Investigation Form	92
VII.	Subrogation Act	96
VIII.	SSI Benefits Memorandum	99
IX.	Data Security Memorandum	103

OHIO MEDICAID CASE STUDY

I. PROGRAM OVERVIEW

A. History

Ohio began making payments to OAA recipients, with Federal financial participation as early as April 1, 1952, and later extended coverage to the other adult categories—AB and APTD programs. By 1962 the program was extended to cover AFDC recipients.

Ohio's Medicaid program began on July 1, 1966, after approval of the original state plan by DHEW on May 15, 1966. The Department of Public Welfare is the single state agency responsible for supervision of the Medicaid program which is administered by Ohio's 88 counties' departments of welfare. The state exercises strong supervision and initiated a statewide MMIS in 1972 which became fully operational in 1974.

B. Program Characteristics

Medicaid eligibility is limited in Ohio; to the categorically needy with no provisions for the medically needy. Payments for Title XIX services in FY76 were $485 million in contrast to the $40 million expended in FY67 when the program began. In FY76 there were 32,000 providers enrolled in the program.

Although technically a state supervised locally administered program, eligibility determination is the major function conducted at the county level. All claims are processed through the DPW operated MMIS system and all activities relating to rate setting, auditing provider education and surveillance and utilization review (S/UR) are performed by the state. The counties contribute to the support of the program at about a 10% average level.

Services covered by the state plan include:

- inpatient hospital services with a limit of 90 days per spell of illness
- intermediate or skilled nursing care services
- all family planning services and supplies
- physician services with a limit of 10 physician visits per month
- podiatric, optometric and chiropractic services with a limit of 10 visits per month and only for specific services in accordance with Federal Medicaid regulations
- psychological services limited to 5 hours per year per person
- home health care
- private duty nursing
- clinic services
- medical supplies with prior authorization
- dental services
- physical therapy
- occupational therapy
- speech and hearing therapy
- transportation

C. Overview of Administration

Exhibit I-1 presents the organization of the Department of Public Welfare (DPW).

The four DPW units primarily involved in the administration of the Medicaid program are:

Division of Medical Assistance—policy formulation, S/UR, and prior authorization

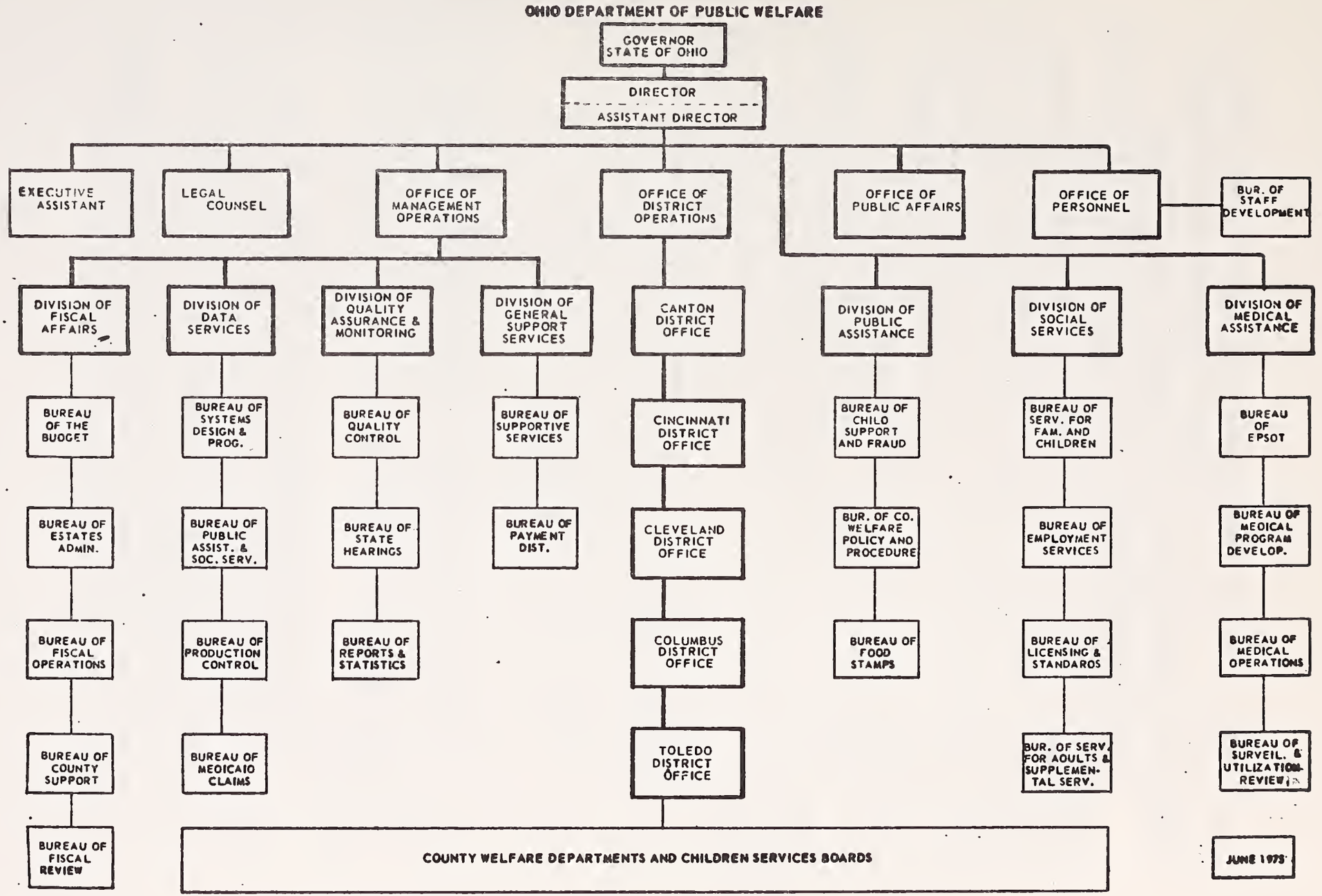
Division of Data Services—claims processing and report generation

Division of Fiscal Affairs—rate setting and auditing for nursing homes and hospitals

Office of District Operations—program support and monitoring in the district offices

Within the framework of county eligibility determination, MMIS claims processing and strong state policy and procedure control, the following units have specific functions relating to fraud and abuse

EXHIBIT I-1 Ohio DPW Organization


OHIO DEPARTMENT OF PUBLIC WELFARE
GOVERNOR STATE OF OHIO
DIRECTOR
ASSISTANT DIRECTOR
EXECUTIVE ASSISTANT
LEGAL COUNSEL
OFFICE OF MANAGEMENT OPERATIONS
OFFICE OF DISTRICT OPERATIONS
OFFICE OF PUBLIC AFFAIRS
OFFICE OF PERSONNEL
BUR. OF STAFF DEVELOPMENT
DIVISION OF FISCAL AFFAIRS
DIVISION OF DATA SERVICES
DIVISION OF QUALITY ASSURANCE & MONITORING
DIVISION OF GENERAL SUPPORT SERVICES
CANTON DISTRICT OFFICE
DIVISION OF PUBLIC ASSISTANCE
DIVISION OF SOCIAL SERVICES
DIVISION OF MEDICAL ASSISTANCE
BUREAU OF THE BUDGET
BUREAU OF SYSTEMS DESIGN & PROG.
BUREAU OF QUALITY CONTROL
BUREAU OF SUPPORTIVE SERVICES
CINCINNATI DISTRICT OFFICE
BUREAU OF CHILD SUPPORT AND FRAUD
BUREAU OF SERV. FOR FAM. AND CHILDREN
BUREAU OF EPSDT
BUREAU OF ESTATES ADMIN.
BUREAU OF PUBLIC ASSIST. & SOC. SERV.
BUREAU OF STATE HEARINGS
BUREAU OF PAYMENT DIST.
CLEVELAND DISTRICT OFFICE
BUR. OF CO. WELFARE POLICY AND PROCEDURE
BUREAU OF EMPLOYMENT SERVICES
BUREAU OF MEDICAL PROGRAM DEVELOP.
BUREAU OF FISCAL OPERATIONS
BUREAU OF PRODUCTION CONTROL
BUREAU OF REPORTS & STATISTICS
COLUMBUS DISTRICT OFFICE
BUREAU OF FOOD STAMPS
BUREAU OF LICENSING & STANDARDS
BUREAU OF MEDICAL OPERATIONS
BUREAU OF COUNTY SUPPORT
BUREAU OF MEDICAID CLAIMS
TOLEDO DISTRICT OFFICE
BUR. OF SERV. FOR ADULTS & SUPPLEMENTAL SERV.
BUREAU OF SURVEIL. & UTILIZATION REVIEW
BUREAU OF FISCAL REVIEW
COUNTY WELFARE DEPARTMENTS AND CHILDREN SERVICES BOARDS
JUNE 1975

control. The specific activities and flow of work will be discussed in greater detail in subsequent sections of this report which describe the specific functional areas of a fraud and abuse control program.

Division of Fiscal Affairs. This division provides all accounting and budgeting services for the department. Within the Division the Bureau of Fiscal Review is most directly related to Medicaid fraud and abuse control. This Bureau's responsibilities include rate setting for and auditing of institutional providers, obtaining repayments owed to the Department as a result of audits, internal auditing of agency staff and procedures, and providing assistance to the Bureau of Surveillance and Utilization Review when auditing assistance is required.

Division of Data Services. This division is responsible for all computer support services to the Department including AFDC payment systems, master Medicaid recipients file, Medicaid claims processing, and the concomitant management reports. In addition, provider education and third party reimbursements are the responsibility of this division.

Office of District Operations. There are five districts in Ohio with the district offices located in:

Canton
Cincinnati
Cleveland
Columbus
Toledo

There are two Medical Assistance Supervisors (MAS) in each district office. In the fraud and abuse control area, the MAS primarily assists in arranging provider education programs in the districts, referring complaints to appropriate officials in Columbus, and assisting in field investigations when necessary.

Division of Medical Assistance. This division has primary responsibility for the operation of the Medicaid program. It conducts its functions through four Bureaus, of which the Bureau of Surveillance and Utilization Review (BS/UR) has primary responsibility for control of fraud and abuse in the program.

The Bureau of Medical Program Development is the policy arm of the program and is primarily responsible for preparing and updating

the provider handbooks. They work with BS/UR when policy changes to control fraud and abuse need to be issued.

Bureau of Medical Operations is primarily responsible for formulating medical policy and administering prior authorizations.

The Bureau of Surveillance and Utilization Review (BS/UR) is responsible for monitoring the providers and recipients involved in the program and detecting and investigating fraudulent and abusive practices. There are 19 staff members in this Bureau organized into two nine member teams under the director. Each team is composed of a supervisor, 5 analysts, 2 field investigators, and one secretary.

In summary, the Bureau of S/UR is the primary focus within the department for provider fraud and abuse control and several other bureaus and divisions have related or support functions.

In addition, there are several state agencies outside of the Department with functions relating to fraud and abuse control in the Medicaid program. These are:

Attorney General's Office. The Attorney General in Ohio represents the state in civil matters. Criminal proceedings are handled by county prosecutors. The Attorney's General Office relates to Medicaid provider fraud and abuse in two ways. First, two assistant Attorney's General are assigned to the Department to provide legal advice and assistance. Secondly, the Claims Settlement Division handles civil recovery actions to recoup funds owed the state.

The State Auditor's Office contains a Division of Welfare Auditing which has specific responsibilities regarding Medicaid provider payments. These include:

- Prepayment authorization in a technical sense for all claims, including a regular review of a sample of claims prior to payment;
- Post payment audits of selected providers;
- Review and assistance concerning DPW auditing procedures;
- Recovery of funds erroneously spent.

The Ohio Department of Health also has responsibilities relating to Medicaid. The Health Department is responsible for providing information

on the licensure of Medicaid providers, and for the inspection of health facilities to ascertain that they meet the health and safety standards required for Medicaid providers.

The 88 County Prosecutors Offices throughout the state are responsible for criminal prosecution of any cases involving provider or recipient fraud.

II. PROVIDER FRAUD AND ABUSE CONTROL PROGRAM

A. Administration

Within the general administration of the Medicaid program, explained in the previous section, the Bureau of Surveillance and Utilization Review has the primary responsibility for monitoring and detecting cases of fraud and abuse. Critical to the operation of this bureau is the MMIS operated by the Division of Data Services. This Division supplies BS/UR with management summary reports of Medicaid providers on a quarterly basis. BS/UR reviews these profiles for indications of aberrant practices. If this review indicates that a potential fraud and/or abuse situation may exist, other detailed reports such as provider profiles, treatment analysis, etc., are requested from Data Services. If review of these items also suggests a possible fraud or abuse, a field investigation and possibly an audit would be conducted. The audit could be requested from either DPW's Bureau of Fiscal Review or the State Auditor's Office. As a result of investigations, several outcomes are possible:

- there may be no evidence of wrongdoing and the case may be dropped;
- there may be errors resulting in a need for recovery but no evidence of fraud;
- there may be abusive practices involved which could lead to a provider's termination or suspension from the program and/or recovery of funds;
- there may be fraudulent practices involving referral of cases to county prosecutors for prosecution as well as civil recovery.

The decision to conduct a field investigation and audit is the responsibility of the Chief of BS/UR. Recommendations involving suspension or termination are to be made by BS/UR but must be reviewed and approved by the Director of DPW before implementation. Negotiating settlements and recovering funds are also the responsibility of BS/UR. If BS/UR has difficulties collecting the monies owed, the case may be referred to the Attorney's General Office. Exhibit II-1 indicates the flow of a typical case through the various divisions and agencies.

As noted previously, BS/UR has 19 staff members to conduct these functions. Staff assignments are primarily administered through the project system described in the investigation section of this report.

B. Prevention

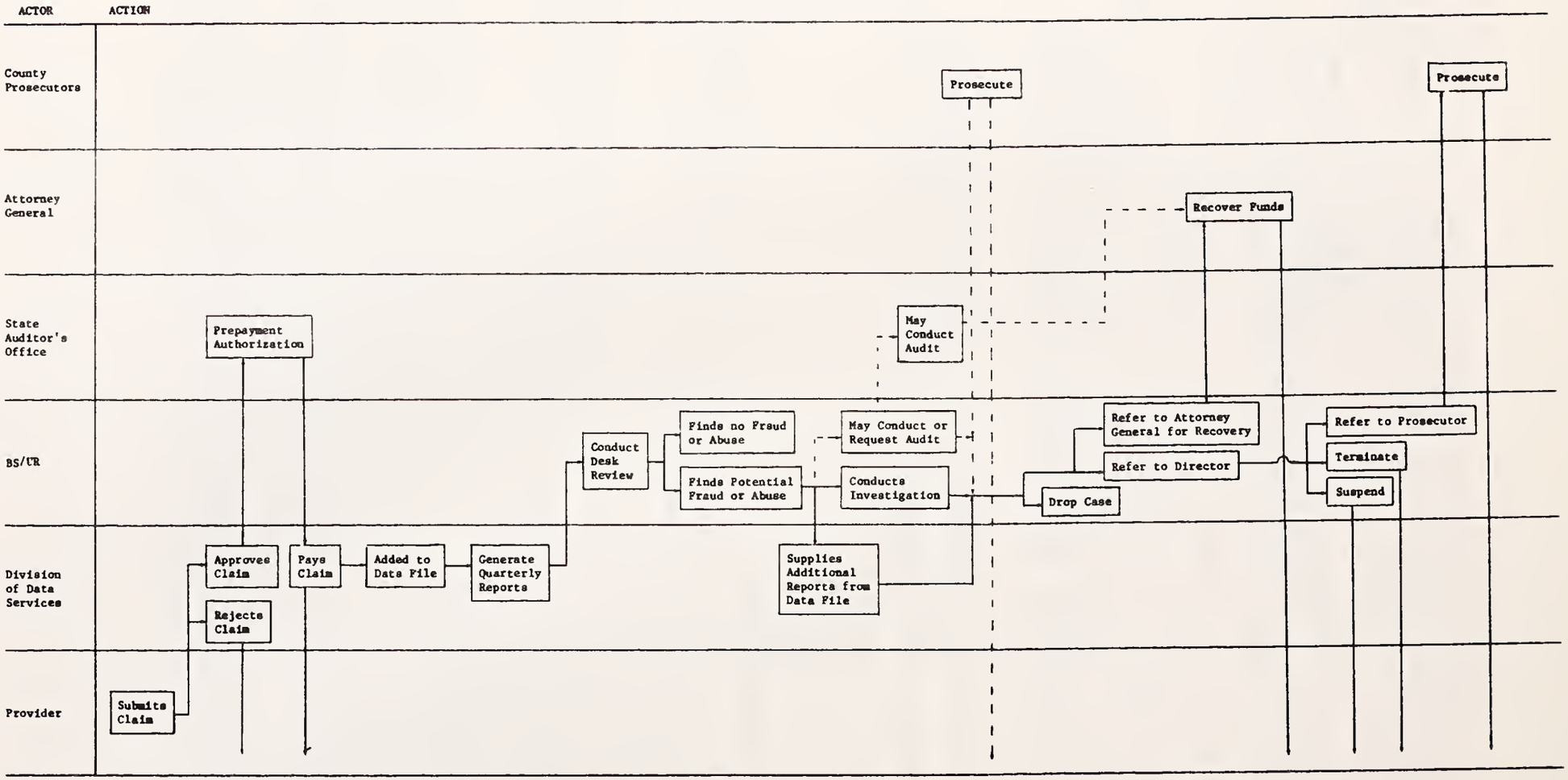
Six functions are performed within the Ohio Medicaid program which can be generically categorized as preventive activities. These functions are:

- Prior authorization;
- Rate setting;
- Prepayment review;
- Certification of level of care for nursing home patients;
- Certification of providers; and
- Provider education.

Each of these functions acts in some manner to facilitate correct and valid claims being submitted in the first place or to prevent payment of incorrect or invalid claims after submission.

Prior Authorization. As in most states, Ohio requires prior authorization from DPW for selected procedure codes. Prior authorizations are used to control the utilization of easily abused or very expensive procedures, usually where a question of medical necessity must be addressed. A classic example of this is dentures for elderly recipients in nursing homes. In this case, the reviewer may question whether the lack of dentures is inhibiting the recipient's functioning and will the recipient use them if they are provided. The Bureau of Medical Operations/Division

EXHIBIT II-1 Case Flow Process



of Medical Assistance is responsible for this function. Procedures requiring prior authorization are determined by the provider specialists in the Bureau and are promulgated in the provider handbooks. Prior to providing a stipulated service to a recipient, a provider must complete a prior authorization request form and submit it to the Bureau. Review of the requests is accomplished primarily by medical reviewers (registered nurses) within written guidelines provided by the Bureau's medical specialists. Selected cases which involve special circumstances or are not of a routine nature are referred to the medical specialists for review. The authorization is approved or denied and returned to the requesting provider with a prior authorization control number or reason for denial. When the provider submits a claim for a procedure requiring prior authorization, he must attach a copy of the approval with the control number. A check for the prior authorization approval is a standard edit check in the claims processing system. If the prior authorization number is not present, the claim is rejected with the appropriate code for "no prior authorization for procedure requiring prior authorization." The claim is then returned to the provider with an explanation for nonpayment. Throughout this process, either at the point the prior authorization is denied or when a claim is rejected, the provider can discuss the case with DPW staff. If a billing error on the provider's part has occurred, he can resubmit the claim for payment.

Rate Setting. Rate setting is a preventive activity to the extent that hospitals and nursing homes are required to submit cost reports and are audited retrospectively to assure that only allowed costs were included in charges billed to the Department.

The Bureau of Fiscal Review within the Division of Fiscal Affairs is responsible for reviewing cost reports from hospitals and skilled and intermediate care facilities to determine the rates at which these institutions bill the program. These institutions are paid on the basis of a "prospective reasonable cost related basis." The rates for each institution are established based on the cost reports submitted by the institution and are fixed to the extent that they are not subject to

retroactive settlement except where misrepresentation of costs and/or services is involved. Specific formulae and ceilings are contained in the Ohio State Plan for Medical Assistance in Attachment 4.19-B, "Methods and Standards for Establishing Payment Rates." (Appendix I). These rates are based on per diem costs required for "the care, comfort, and safety" of patients. Generally all other services, such as prescription drugs, physical therapy, etc., must be billed directly by the provider. Approximately a dozen hospitals are on all-inclusive rates. Rate setting for hospitals is accomplished primarily through desk audits using the Title XVIII cost reports. The state is not on common audit with Medicare. Only 160 of the 900 extended care facilities in the state are Medicare providers, so the state has its own cost reporting and rate setting procedures for nursing homes.

Since all rates are interim until the cost reports have been received and analyzed, the finalization of rates does not occur until some period of time after the point in time the service was provided and billed for.

Rates for nursing homes are established semi-annually and the Bureau is approximately one year behind in finalizing rates. Hospital rates are established on an annual basis. The January 1, 1975 cost reports will be used to determine the January 1, 1977 prospective rates.

There are approximately 900 skilled nursing facilities and intermediate care facilities in the program as well as 220 hospitals for whose rates this Bureau is responsible.

Prepayment Review. This function involves two activities. The first is the standard edit checks applied during claims processing. The second is a review of payments by the State Auditor; Ohio law requires the certification of all payments by the State Auditor.

Appendix II is a list of the edit checks and error codes used by the Division of Data Services. Included in these error codes are many which prevent payments of claims which may involve fraud or abuse. Examples of such checks include:

- Type of claim/service invalid
- Submitted procedure charge greater than authorized payment amount

- Place of service in conflict with procedure code
- Beginning date of service prior to admission date
- Procedure code conflicts with provider type
- No prior authorization for procedure requiring prior authorization
- Non-compatible sex codes in procedure and diagnosis records
- Drug quantity not within minimum and maximum range
- Provider not eligible at time of service
- Recipient master file does not show recipient in nursing home
- Duplicate or conflicting claim

When a claim is rejected by the computer, claims processing staff manually review the claim to determine if the reason for rejection is merely an error such as a keypunching error, transposed digit, etc. If this is the case, the claim is corrected and resubmitted for processing. If the error is not mechanical, the claim is returned to the provider with the appropriate explanation for nonpayment.

Since DPW recognizes that a claims processing system is susceptible to agency staff collusion with providers to expedite claims, override the edit programs, or "fixing" claims which the computer has rejected, the Director of the Division of Data Services has begun promulgating new safeguards in this area. One such procedure currently being tested for its practicality is that each claim which is fixed within the Division for resubmission for processing must be co-signed by a supervisor. A more detailed discussion of agency fraud is presented in a subsequent section of this report.

Copies of all claims initially approved by DPW are then sent to the Division of Welfare Auditing of the State Auditor's Office. The Auditor's Office maintains its own transaction tape which indicates the proper charges and codes for specific services, previous billing, and other pertinent information. Each month the Auditor's staff selects a statistically valid sample of claims and carefully reviews them. On all bills in which an overpayment is identified, DPW is notified and payment for such claims is not authorized. This system provides an additional check on the appropriateness of claims before they are actually paid.

It also provides a validation of the payment amount.

Certification of Level of Care. The State Plan for Medical Assistance requires that medical review be conducted for each recipient in a skilled nursing facility. This review includes medical evaluation of "each patient's need for care in such facility, a plan of care, and, where applicable, a plan of rehabilitation."* This requirement prevents payment for recipients not in need of skilled care.

The Nursing Home Licensure Section of the Bureau of Medical Operations is responsible for overseeing the required reviews. However, the specific reviews of individual recipient's cases are carried out by county welfare offices.

Certification of Providers. All providers in the state are eligible to participate in the Medicaid program for provision of covered services for which they are licensed or certified. Eligible providers must sign a provider agreement and are issued a provider number by DPW. Licensing and certification are by state law the responsibility of other state agencies who coordinate with DPW. Certification of providers is preventive to the extent that it precludes providers who do not meet specified standards from participating and identifies the specialties in which the provider is considered qualified to practice.

Attachment 4.16-A, "Plan for Administration of Title XIX," to the State Plan addresses the issue of standard setting for institutions and cites the Department of Health as the responsible agency in accordance with relevant sections of the Ohio Revised Code. The Departments of Public Welfare and Health have operationalized this responsibility for the Title XIX program through the execution of a cooperative agreement. This agreement specifies that DPW sets the standards for participation in the Title XIX program for skilled nursing and intermediate care facilities and that the Health Department shall evaluate and certify skilled nursing and intermediate care facilities for compliance with

---

*Section 4.15, Periodic Medical Review and Medical Inspections of Skilled Nursing Facilities and Mental Hospitals. Ohio State Plan for Medical Assistance, p. 17.

Title XIX and other state certification requirements. The Department of Health is also responsible for certifying that Ambulatory Health Care Center/Organizations, as defined by DPW, meet the Conditions of Participation. The Health Department also provides DPW with lists of "those facilities certified as meeting the conditions of participation under Federal and State authority"... The facilities specified include:

- Licensed nursing homes, rest homes, homes for the aging
- Skilled Nursing Facilities
- Intermediate Care Facilities
- Home Health Agencies
- Certified Hospitals
- Independent Laboratories

The Department of Health is also obligated to advise DPW of any change in status for any of these institutions.

The state plan also identifies the Ohio Department of Industrial Relations as responsible for determining facilities' compliance with life safety codes, and the State Fire Marshall's Office as responsible for determining facilities' compliance with fire regulations. A cooperative agreement for this purpose exists between the Departments of Public Welfare and Industrial Relations.

Since the state does not have a healing arts act, nursing home administrators are licensed through a state licensing board established to meet the Federal requirements.

Physicians are licensed in the state through the State Medical Board. All providers applying to participate are screened through the applicable state examining board and are permitted to provide services to program recipients for which they are recognized to be qualified by the appropriate examining board.

Provider Education. Provider education is a preventive function to the extent that it assists providers in submitting valid and correct claims and makes providers aware that claims are reviewed to detect abusive and fraudulent practices.

Within the Division of Data Services/Bureau of Medicaid Claims there is a Provider Assistance Unit. One function of this unit is to conduct

provider education when required. Primarily this education takes the form of special training in billing procedures. For example, at the time of the data collection visit (June 1976) DPW was beginning to institute machine readable claims forms and the provider assistance unit was conducting training for providers in the use of the new forms.

The Division of Medical Assistance/Bureau of Surveillance and Utilization Review has also conducted limited provider education. This has primarily taken the form of presentations to provider associations and articles in professional journals describing the BS/UR functions.

C. Detection

Two entities within DPW are concerned with detection, as is the State Auditor's Office. Within DPW, the Division of Data Services processes claims and applies the edits discussed in the previous section of this report. Data Services also generates the special reports used to detect abusive or fraudulent practices. The Bureau of Surveillance and Utilization Review uses these reports and other sources to detect practices worthy of investigation. The State Auditor's Office by virtue of its prepayment review function and audit responsibilities assists DPW and acts independently to detect potential cases.

Division of Data Services. Within the Bureau of Systems Design and Programming of the DDS, there is a Medicaid Unit responsible for generating reports and designing new reports to assist in the detection process. Reports which can be generated from the MMIS are presented as Appendix III. Management Summary reports for providers are generated on a quarterly basis. A sample of a Management Summary Report: Provider Class Profiles (hospitals) is presented as Appendix IV. From the summary reports the Bureau of Surveillance and Utilization Review (BS/UR) staff perform analyses and request more detailed reports as necessary.

The Bureau of Systems Design and Programming staff also work with the BS/UR staff to design new reports or modify existing reports to further enhance the detection process.

Division of Medical Services/Bureau of Surveillance and Utilization Review (BS/UR). This is the office primarily responsible for both detection

and investigation. Each quarter the computer reports cite approximately 2500-3000 providers who "except" on one or more of the exception criteria. An "exception" is two standard deviations from the provider group average for each criterion being applied. Clerical staff manually review the exceptions; sort them by provider type; and screen out those providers who are "excepting" for the first time. The work load on BS/UR staff is such that a provider generally excepts for three quarters or more, establishing a clear pattern before BS/UR staff begin reviewing the case. As a result of this clerical screen approximately 600 providers per quarter are "detected" of which a maximum of 200 can be handled as active cases.

It must be noted that the data base from which the computer reports are generated is paid claims and does not include all of the questionable claims initially rejected by the edit programs.

Although BS/UR staff continue to work on individual cases, in recent months the Bureau has attempted to prioritize staff activities through a categorical approach to abuse. Based on the pattern of exceptions, complaints and other sources, the staff is now attempting to develop "project designs" which address a category of provider or abuse. Since December 1975, this approach has been used to address problems with ambulance providers, podiatrists, drug utilization, and medical supplies. As a team identifies a problem area, they develop a project design with a specification of the problem under study, a methodology or approach to the study, time frame, resources required, etc. The Bureau Director and senior analysts then assign the project a priority within the Bureau and a deadline for completion. They also assign a team of analysts/investigators. A sample of the project design for a study of medical supplies utilization is presented as Appendix V. The following is a list of the Bureau's priority projects as of March 1976:

Project and Rank

1. Drug Substitution Study
2. Split Prescriptions
3. Podiatric Services in Cuyahoga County

4. Prior Authorizations for Medical Supplies
5. Limited Practitioners (Chiropractors, Licensed Therapists, etc.)
6. Drug Overpayments, Phase 2
7. Medical Science Clinic Medical-Fiscal Audit
8. EOMB
9. Direct Entry Contracts
10. Psychological Services

To summarize, the Bureau has attempted to maximize its resources and organize its detection process so that investigations are undertaken on the highest priority issues that appear to have the largest program-wide benefits.

State Auditor. In addition to its prepayment review function, the Welfare Auditing Division may conduct audits on any provider or category of providers. Recently, high priority has been placed on reviewing nursing homes. A random sample of 121 homes has been selected for review. The auditor's office also selects cases based upon anonymous tips, review of high volume providers, and reviews of provider's billing procedures which may indicate questionable practices.

D. Investigation

There are two entities within the state government where Medicaid provider fraud and abuse investigations are primarily focused: the Bureau of Surveillance and Utilization Review (BS/UR) of the Department of Public Welfare and the State Auditor's Office. DPW District Offices, County Welfare Departments, and other DPW and state agencies assist in specific investigative activities when requested by one of these two agencies.

Bureau of Surveillance and Utilization Review. Within DPW this Bureau has primary responsibility for detecting and investigating fraud and abuse within the Medicaid program. As discussed in the previous section on detection, BS/UR has in the last six months begun to focus its investigations through specific investigation "projects" aimed at categorical problems—primarily one category of providers or services.

The Bureau has adopted this procedure because of several considerations:

- The reports available from the MMIS generate large numbers of potential cases, far in excess of the staff resources available to investigate them individually and prioritization is mandatory.

- Project designs with tasks, objectives, staff assignments and deadlines provide a framework within which staff can work, define their personal responsibilities and be supervised and evaluated in a more efficient manner than in the individual caseload system.

- Staff can specialize in particular categories of providers, services or problems and thereby enhance their expertise.

- Establishment of project designs and time schedules allows for better planning for additional resources required such as district office staff for field investigations, etc.

- Since investigations can go on for months without absolute closure, the project approach allows staff to define phases and accomplish discrete tasks, therefore enhancing staff morale through functional closure.

- The project approach allows staff to deal with broader issues than an individual provider's abuses. Therefore, as a result of a project, the staff may be able to document that a certain practice is prevalent throughout a provider type and that procedural, regulatory, or legislative change is warranted and more cost effective than investigating and documenting individual cases repeatedly in the particular category.

BS/UR staff has found that "project" investigations take relatively little more time than an indepth investigation of a single provider, usually with a significantly greater payoff. Occasionally, however, large individual cases are managed as "projects" because they require large allocations of time by multiple staff members.

A sample project design is presented as Appendix V and was previously referenced.

As noted previously, BS/UR is organized into two teams each headed by a supervisor and staffed by five analysts, two field investigators, and a secretary. In general, one of the supervisors heads a project team and staff are assigned to the team on a full-time or part-time basis, as required.

It must be noted that BS/UR staff generally talk in terms of projects or studies and not investigations. Procedures involved in a study usually include:

- Desk Audit of available data. This usually involves requesting various detail reports from Data Services and performing manual analyses; for example, comparisons within a provider category by ownership type, geographic location, or institutional size; estimating size of overpayments once criteria for calculating have been established, etc.

- Field Investigations to visit facilities and providers to gather information, discuss problems, interview recipients, etc.

- Consultation with specialty staff or consultants to review findings, refine project procedures or develop recommendations.

The outcome of a project is a project report, either for the total project or the phase completed. Actions resulting from these reports are discussed in subsequent sections on prosecution, referral, and administrative actions.

The Project Approach. To illustrate the project approach used by BS/UR several examples have been selected:

- Prescription Splitting. A manual review and analysis of pharmacy claims on the provider summary report suggested that prescription splitting was a major problem. A review of the pharmacy provider handbook demonstrated that existing regulations were not sufficiently clear in this area. Therefore, BS/UR undertook negotiations with the Bureau of Medical Program Development to strengthen Department policy in this area and notify providers of the policy modifications.

  Concomitantly, BS/UR staff and a member of the Auditor's staff worked with Division of Data Services staff to develop a new report specifically designed to detect splitting without extensive manual analysis required. This approach of regulation strengthening and developing a new computer report greatly minimizes the staff time required to "investigate" and resolve these cases. Based on the current regulation language, claims representing splitting can be almost automatically detected and payment adjusted.

- Ambulance Services. When an analyst had accumulated approximately 60 individual cases to be investigated around the use of ambulance services, it was decided to conduct a preliminary study which led to a major project on ambulance services statewide. Initially four ambulance companies, fifty-four recipients and 411 trips were investigated. This analysis led to a pattern of problems which suggested that 37% of the

costs to the Department could have been saved. As a result of this preliminary finding, a major project design was prepared. A desk analysis revealed that 3.57% of the providers accounted for 73.69% of program expenditures for this service.

The study was enlarged to 11 ambulance or "ambulette" companies, 90 recipients and 751 trips. The patterns found in the first sample continued to be evident and again a potential of a 37% savings was determined. A third level of review and expansion of the sample continued to substantiate initial findings. At the time of the data collection visit, the study was not completed, but recommendations for changes in reimbursement and administrative policies were expected to result.

- Hospital Utilization. BS/UR has become interested in the utilization of ancillary services in hospitals (lab, X ray, pharmacy), utilization of emergency rooms as a primary source of medical care by program recipients (both in terms of quality and continuity of services to recipients and cost to the Department higher than physician's office visits), and the diligence of hospitals in billing Medicaid only as a last dollar source. BS/UR has assigned a project team to review hospitals who except regularly on a large number of criteria. This has been implemented through manual analysis of individual hospital's profiles; detailing of apparent problems; and visits to the hospitals to discuss these problems and check additional activities. A checklist of items used by BS/UR staff during these visits is attached as Appendix VI. As part of this procedure questionable claims are pulled and the hospital is asked to check these claims against their records. An example of this is claims which DPW has identified as involving recipients who are Medicare beneficiaries, but for whom the hospital has billed DPW for all services rendered. A subsequent visit is then scheduled to review the hospital's implementation of corrective actions.

  This initial work with selected hospitals is expected to also result in new policies and regulations and perhaps new MMIS reports.

In each of these cases projects involving selected providers and relatively short time frames (3-6 months) have resulted or are expected to result in system and policy improvements which will correct a problem and forestall the need to investigate many individual cases for similar aberrant practices. While this approach to investigations has benefits in terms of the application of scarce resources, it requires a willingness to forestall future abuses as the goal. Therefore, any results relating

to a specific provider such as prosecution, recoupment or administrative penalties are mere by-products and are not goals or objectives of the Department.

The Bureau provided the following statistics on its active investigations for Fiscal Years 1973-1976.

FY73	133 providers investigated
FY74	146 providers investigated
FY75	539 providers investigated
FY76	661 providers investigated (through December 1975)

As noted previously, other organizational units may be involved in an investigation at the request of BS/UR. These organizations and their roles include:

- Bureau of Fiscal Affairs/DPW. As discussed in the prevention section, this is an auditing unit primarily responsible for institutional rate setting. Theoretically this unit can also provide auditing assistance to BS/UR as part of an investigation. In fact, this Bureau has not done a provider audit at the request of BS/UR in approximately two years due to its own workload priorities.

- State Auditor's Office. In lieu of assistance from the Bureau of Fiscal Affairs, BS/UR has turned to the Auditor's Office for auditing assistance. Since this is not a required function of the Auditor's Office, BS/UR must rely on being able to interest the Auditor's Office in a particular project or case and on the availability of the Auditor's staff.

- District DPW Offices. There are five district offices around the state and each has two Medical Assistance Supervisors. The Medical Assistance Supervisors and other District Office staff can be asked to participate in a particular investigation, primarily when field visits to a large number of providers are required.

- County Welfare Departments. The County offices can be asked to supply particular information, interview recipients, or provide other assistance.

- Bureau of Medical Operations. Medical consultants, who are primarily involved in program medical policy formation and prior authorizations, are employed by this Bureau. However, their assistance can be requested to provide advice on specific cases. In general, however, BS/UR hires its own specialty consultants or uses specialists from other agencies. The availability of these consultants is limited and not a satisfactory situation for any of the parties.

- DPW Legal Counsel. The legal counsel can be consulted concerning the legal and policy implications of an investigation. If a potential lawsuit is involved, the DPW legal counsel can consult with the Assistant Attorney General assigned to the Medicaid program.

- Other agencies. Other agencies can be involved when their legal jurisdiction or expertise is relevant. However, they are more likely to be involved as a receiver of referrals once a case has been developed. Instances when they can be of assistance during an investigation include (1) the Health Department inspecting an independent laboratory, nursing home or other facility suspected of being out of compliance with the conditions of participation; (2) the Medical Advances Institute (statewide PSRO), professional societies where allegations involving professional ethics, etc., are involved; or (3) State Fire Marshall or Department or Industrial Relations where investigation for violation of life safety codes is required.

Federal officials may also become involved in investigations. This has only happened in the case of a current special investigation, where at the request of the Governor, DHEW investigators have been assigned to a case.

State Auditor's Office/Division of Welfare Auditing. In addition to assisting BS/UR on investigations, the State Auditor has independent authority to conduct investigations of state programs. Therefore the Division can and does select and investigate providers. Of course these investigations are limited to the issue of whether the state paid a correct amount for the services rendered. As a result of these investigations/audits, the Auditor's Office recovers a large amount annually in cases where quantity discounts were not passed along to the state in the form of lower charges, documentation did not exist to prove services were rendered for which claims were paid, etc. The amount of recoveries is discussed in that section of this report. The auditor provides copies of his reports on all investigations to DPW.

Division of Data Services, Third Party Claims Unit. Besides BS/UR and the State Auditor's Office, there is a third unit that conducts investigations. This is the Third Party Claims Unit in the Division of Data Services. However, as this unit has developed over the six months since its inception, its activities are more directly related to individual recipients than to providers. Therefore, the discussion of this unit's functions is presented in Section III of this report.

E. Outcomes

Administrative Sanctions. Ohio's policy with regard to aberrant practices on the part of providers is oriented toward provider education and strengthening Medicaid Program policies to prevent fraud and abuse. On the whole, little emphasis has been placed on taking administrative actions against providers.

There are no formal policies in existence for holding hearings for providers, terminating providers, or suspending providers. Exhibit II-2 presents a memo giving the number of investigations, terminations and referrals for prosecution. Most terminations were due to loss of license, death or a move out of state rather than as a result of fraudulent or abusive practices.

When BS/UR is conducting an investigation, it will frequently hold "informal conferences" with providers. Such conferences are typically held to discuss billing problems which providers claim are due to clerical error. The conferences may only involve BS/UR staff, the provider and his bookkeeper, or they may include the provider's attorney and the Department's legal counsel. Such conferences typically serve to educate the provider and his staff, and to determine the amount of any repayments which are necessary.

The most significant legal issue in Ohio is not involved with criminal cases, but with civil actions and administrative procedures as outcomes of investigations. The Department has no formal administrative procedures either for administrative sanctions, such as suspension, or for hearings to provide due process for providers if administrative sanctions are to be imposed. The state Administrative Procedures Act (which provides the hearing procedures in most states for provider hearings) does not apply to the Medicaid program in Ohio.

The result of this status is that the Department has not tried to implement suspension since it is assumed that the court would issue a writ of mandamus for release of funds unless the provider had available an administrative appeal route through a departmental hearing.

As with criminal prosecution, there is only one example of a case to cite. In the particular case the providers had been indicted in county courts on criminal fraud charges. Based on an audit, the DPW had asked for repayment of certain funds. The provider's attorney insisted on an informal evidentiary hearing to clarify the facts in the case. In this case the DPW legal counsel acted as moderator and used a review panel consisting of staff from the Division of Medical Affairs and Bureau of Fiscal Affairs. This "hearing" apparently had the legal status of an informal provider conference and really served to review the case for the providers and their attorney.

DEPARTMENT OF PUBLIC WELFARE

INTER-DEPARTMENTAL REFERENCE

OPW 78 (7/67)

February 10, 1976

TO: Art Robinson, Director
Office of Public Affairs

FROM: Roger W. Brown, Chief
Bureau of Surveillance & Utilization Review

SUBJECT: S/UR STATISTICS FOR FY 1973, FY 1974, FY 1975 AND FY 1976 THROUGH DECEMBER 31, 1975

FY 1973

Providers Investigated	133
Providers Terminated	6
Provider refunds resulting from audits	$108,033

FY 1974

Providers Investigated	146
Providers Terminated	7
Provider refunds resulting from audits	$ 93,292

FY 1975

Providers Investigated	539
Providers Terminated	22

FY 1976 (through December 31, 1975)

Providers Investigated	661
Providers Terminated	151
Funds identified for recovery	$ 73,846

In FY 1973 one of the providers terminated was for apparent fraud. This was referred to the Attorney General's Office but the case was not prosecuted.

In FY 1975 two provider cases were turned over to law enforcement officials for fraud. They both were indicted by the Franklin County Grand Jury and both were subsequently convicted and fined.

RWB:mt
cc: Joe Hoffer

Exhibit II-2

Prosectuion. By its own description, the Department of Public Welfare is not a prosecution-oriented agency with respect to Medicaid providers. As described in the previous section of investigations, both philosophically and procedurally, the Department works toward identifying problem areas and attempting through regulation and procedures to deny the opportunity to providers to continue to use questionable practices. In addition to this philosophy, the BS/UR staff by training and background are not investigators in the law enforcement sense, but rather analysts in the research and education sense. Staff backgrounds are generally in the social sciences (education, sociology, health).

In addition to the BS/UR staff, there is a Counsel and Assistant Counsel on the Department's staff. They function at a staff level and are responsible for advising the Department staff and ultimately the Director and Assistant Director on legal issues involving the Department. Specific court actions are handled by the Attorney General's Office (civil actions) or the County Prosecutors (criminal actions). The function of the DPW Legal Counsel is primarily one of advice on case development.

Criminal cases in the State of Ohio are handled by the elected county prosecutor in each of the 88 counties. Misdemeanor charges are filed in County Court and felony charges are filed in the Court of Common Pleas. Felony charges require indictment by the county grand jury. Charges can be brought under the General Fraud and Theft Section of the Ohio Revised Code (2913.02).

Section 5701.04 of the Ohio Revised Code contains language concerning fraud in the ADC program. There is no language concerning fraud in the Medicaid program. In Ohio fraud is defined as a single transaction involving more than $150. Therefore, individual provider bills would have to represent fraud in excess of $150 for the statute to apply, as currently interpreted by the Department. A series of bills involving less than $150 worth of fraudulent charges each, no matter what the total amount of fraudulent charges on the compiled bills would represent, would not justify a fraud charge under state law as interpreted by the Department.

Given this legal framework, if DPW wished to prosecute a provider, it would work through the DPW legal counsel to present the case in terms of the charges the case would appear to warrant to the county prosecutor in the appropriate county. The county prosecutor has sole jurisdiction to determine what prosecutions will be pursued in his county.

There is only one recent case to cite as an example of this process. The case involved two physician providers who own a corporation which for several years had been under scrutiny by DPW for various abuses and alleged fraudulent practices. The Franklin County prosecutor preferred charges against both the corporation and the individuals involved. However, as a result of plea bargaining the charges against the individuals were dropped and the corporation plead guilty to a lesser count and received a $3500 fine. This is the only case in recent years, and, therefore, the only example which can be cited as to how this process works.

Recovery. Recovery of funds may be obtained by BS/UR. Generally, this unit has been successful in obtaining restitution. Although one provider did flee the state to avoid payment, in most cases the providers have typically pay the money back immediately or the amount owed has been subtracted from claims submitted. BS/UR generally does not allow the amount owed to be deducted from future claims.

The Bureau of Fiscal Review also seeks recovery when retrospective audits indicate that overpayments were made to institutions. It is the belief of the unit that most of the adjustments are necessary because of lack of education and error rather than fraud. When an amount of overpayment is determined, a summary report is prepared and the provider is notified. The provider has 30 days in which to make payment or request a hearing. If a hearing is requested, it is conducted by an Audit Review Panel, which is comprised of the Director of the Division of Medical Assistance, the Director of the Division of Fiscal Affairs, Legal Counsel, the Fiscal Affairs Assistant responsible for collections, and the Director of the Division of Public Assistance. The Director of DPW must concur with all decisions made by the Panel. Exhibit II-3 presents samples of the forms used to notify providers of payments owed. If payment cannot

STATE OF OHIO
JAMES A. RHODES, GOVERNOR
KWEGYIR AGGREY, DIRECTOR
RAYMOND F. McKENNA, ASS'T DIR.
STATE OFFICE TOWER
32nd FLOOR
30 EAST BROAD STREET
COLUMBUS, OHIO 43215
(614) 466-6282

OHIO DEPARTMENT OF PUBLIC WELFARE

DIVISION OF FISCAL AFFAIRS

Dear

This is notification that your account pertaining to audit no._____for the period_____ for_____due the Ohio Department of Public Welfare has been released to the Attorney General's Office for collection.

All further correspondence pertaining to this audit should be addressed to:

Mr. Michael Loughman
Assistant Attorney General
Claims Section
Attorney General's Office
30 E. Broad Street, 16th Floor
Columbus, OH 43215

Sincerely,

William E. Stone, Chief
Division of Fiscal Affairs

WES/lac

Exhibit II-3

PROVIDER REPAYMENT COLLECTION FORMS

STATE OF OHIO
JAMES A. RHODES, GOVERNOR
RAYMOND F. McKENNA, DIRECTOR

STATE OFFICE TOWER
32nd FLOOR
30 EAST BROAD STREET
COLUMBUS, OHIO 43215
(614) 466-6282

OHIO DEPARTMENT OF PUBLIC WELFARE

DIVISION OF FISCAL AFFAIRS

Dear

On _____you were mailed a Summary Report from the Bureau of Fiscal Review stating that _____was due the Ohio Department of Public Welfare as final settlement of Audit No._____ for the period_____.
This is notification that payment is required from you by _____.

State Statute 115-10 requires that we make demand for payment of monies due the State of Ohio within 30 days after notification of debt. Any funds not collected within the 30 day limit are considered delinquent and are required, by law, to be released to the Attorney General's Office for collection.

Since it is our desire to prevent legal action, if possible, please advise as to when we may receive payment.

Sincerely,

William E. Stone, Chief
Division of Fiscal Affairs

WES/lac

cc: Richard D. Telkamp
Ohio Hospital Association

Exhibit II-3

PROVIDER REPAYMENT COLLECTION FORMS

be made within 30 days but the provider agrees to make payment, a plan for paying back the monies owed over a six-month period can be made. If a provider refuses to make payment, the case is turned over to the Attorney General's Office for civil recovery action.

At the time of this site visit, the audit staff had completed retrospective audits for the period of 1967 through 1971. During this time approximately three million dollars in overpayments were identified, and two million dollars had been collected.

The State Auditor's Office also audits providers as part of its ongoing independent authority and responsibilities. Over the last three years the Auditor has identified $900,000 in overpayments made to providers.

Copies of all audit reports are routinely sent to the local prosecutor for the jurisdiction involved, the Attorney General, and DPW. If the audit results in findings that the provider received overpayments and owes the state repayment, the provider is so notified by letter and given 30 days to make payment. If payment is not received in the 30-day period, the case is turned over to the Attorney's General Office for civil recovery action. The welfare auditing staff reports that the few cases that do result in civil court proceedings are usually lost by the State due to the ambiguity of the Medicaid regulations.

F. Program Assessment

Introduction. These case studies are written to present the data collected in site visits to selected states. The visits were not designed as evaluations of the states involved. The states selected were those believed to be the jurisdictions with the best fraud and abuse control programs or with other unique characteristics that were most likely to result in "best practices" or ideas for "federal options." In order to identify and analyze "best practices" and "federal options" it was necessary to collect data on the entire state program so that the analyst could understand the environment in which the "best practice" exists and under what circumstances it is effective. The information presented in this report represents the facts concerning the State of Ohio recorded and reported as faithfully as possible.

However, since each jurisdiction has unique characteristics which are non-exportable and, therefore, not "best practices" as defined for the purposes of this study, it is necessary to make some comments on the unique aspects of the environment of each state and document the perceptions of the analysts who collected the data.

Assessment as Reported by State/Local Jurisdiction. The Ohio Department of Public Welfare was under severe financial constraints at the time of the data collection visit. At that time (mid-June 1976) no provider claims had been paid since mid-May due to a lack of funds and the resolution of this problem did not appear to be imminent. Although the Department appeared to be functioning normally, everything was conditioned by the lack of funds. For example, there was expressed concern about continued provider participation due to the low fees paid by the State since fee schedules had not been updated in several years. Given the financial crisis in the Medicaid program, the problem was exacerbated since it is highly unlikely that fee schedules can be revised anytime in the near future. Clearly, a great deal of top program managers' time was being consumed in negotiations concerning resolution of the budget problem.

In terms of fraud control, the budget problems affect the staffing levels in two key bureaus—Surveillance and Utilization Review and Fiscal Review. Fiscal Review has a substantial backlog of work and has been unable for some time to assist BS/UR in investigating providers. BS/UR needs additional staff, particularly in specialized areas, such as the legal matters.

The staff of DPW describe the department as using a "very practical approach." Compared to other states this approach includes a non-prosecution orientation. Therefore, practices and data relating to investigations leading to prosecutions do not exist in Ohio. The state is proud of the MMIS and the editing of claims and special reports capability the system has. Using this capability, the BS/UR staff uses the "project" approach to investigations which the staff is very enthusiastic about. This approach rationalizes their workloads, allows one "study" or investigation to encompass many providers, and allows staff to develop enhanced

skills in particular skill areas or provider categories. This approach is appropriate in terms of the staff's background and the department's philosophy. However, there is staff debate as to the necessity for increased emphasis on referrals for prosecution.

The Department, in general, felt that increased attention should be placed on administrative sanctions and the tools and methods available to the Department in working with abusive or fraudulent providers. The Department was just beginning to address the issues of developing formal hearings procedures and attempting to identify potential administrative penalties.

The fourth descriptive characteristic which is unique to Ohio in terms of the states which have been involved in this study is the active involvement of the State Auditor's Office and the characteristics of the state government which apparently contribute to this. In Ohio a number of the cabinet-level positions, including the Attorney General, the Secretary of State, and the State Auditor, are filled through election. The Director of the Department of Public Welfare is appointed by the Governor and confirmed by the legislature. Currently, the State Auditor was selected from a political party different from the Governor's. While legitimate arguments can be made on both sides of the issue as to the virtues of filling top level positions in addition to the Governor's through election, the current situation in Ohio appears to have beneficial impacts. The State Auditor has legislated responsibilities which would be conducted regardless of the political situation. One of these is authorization of payments from state funds, including payment of Medicaid claims. It is the Auditor's legal responsibility to review payments primarily to assure technical accuracy by the agency making the payments. However, the Auditor also has authority to retrospectively audit providers to whom the State has made payments and calculate any overpayments made by the State for a variety of reasons. The opposing political persuasions of the Governor and the State Auditor appear to have resulted in a synergistic relationship of active commitment by the State Auditor to Medicaid provider problems. Since DPW has significant budget and, therefore, staffing limitations, the active involvement of the State Auditor has

at least resulted in the availability of additional manpower for certain types of provider problems.

This active and continuous involvement of another state agency supplementing DPW staff is unique to Ohio in terms of the states visited for this study. We have observed states where investigations were conducted by another state agency instead of the single state agency or where other state agencies assisted on an ad hoc basis, but only in Ohio was a situation described where another state agency continuously and somewhat independently pursues provider fraud and abuse problems.

Conclusions. The observations of data collection staff largely coincide with those of DPW staff in Ohio. The three key characteristics of the State are the State's MMIS capability which affects all other aspects of program administration, the project approach to "investigations," and the role of the State Auditor. These characteristics affect the best practices which are described in a subsequent section of this report.

Another observation of Ohio is that, unlike other states visited, Ohio has several large urban areas. In other states, the state's activities were concentrated or characterized by one large urban area constituting a major part of the program (Michigan, Wayne County/Detroit; Maryland, Baltimore City and the metropolitan Washington, D.C. area; Massachusetts, Boston). Unlike these states, Ohio has a more generally distributed population with several large urban areas (Cleveland, Columbus, Cincinnati), medium sized cities and counties (Toledo, Dayton) and rural counties. The population distribution in a state affects the summary data available, the staff and workload distributions and the problems encountered. In states with an overwhelmingly large urban area, state summary data describes that urban area. In Ohio state summary data are more truly an average of big and little areas. Ohio is now in the process of developing groupings of providers to generate reports which describe norms for providers in urban areas versus those in medium sized or rural areas.

Secondly, Ohio can not easily assign staff by geographic area. One large field office would not suffice in Ohio whereas it does in some other states.

This characteristic affects other things such as the number of county prosecutors, courts, local professional societies, etc., the staff has to work with.

Therefore, in some ways Ohio may be more representative of mid-western and western states with multiple population centers than of the eastern industrial states with one major population center.

III. RECIPIENT FRAUD AND ABUSE CONTROL PROGRAM

A. General Description

Since Ohio does not have a medically needy program, medicaid eligibility separate from eligibility for other categorical programs (SSI & AFDC) is not a potential problem in Ohio.

Although Ohio is a county administered AFDC state, all counties use the computerized eligibility data base in Columbus. Counties are responsible for determining eligibility, opening, closing, and updating cases. All of this information is transmitted to Columbus from which both checks and Medicaid cards are issued.

Therefore, the only direct recipient problems the Medicaid program (as distinguished from AFDC) is concerned with is coordination of benefits and program abuse/misutilization. There are two units involved with these problems:

- Bureau of Surveillance and Utilization Review (misutilization)
- Third Party Claims/Division of Data Services (coordination of benefits)

B. Misutilization of Services

The Bureau of Surveillance and Utilization Review (BS/UR) is responsible for surveillance of recipient's utilization as well as surveillance of providers. The "lock-in" program (described below) currently being instituted on a demonstration basis in Franklin County is the only "program" designed for this purpose. However, on an ad hoc basis other activities are conducted. For example, as part of the study of hospital outpatient services, one item of the investigator's checklist is whether the records of a recipient's emergency room visit are forwarded

to the family physician. BS/UR feels that recipients overutilize emergency services and thereby receive fragmented care. Since an emergency room visit averages approximately $30 in the State in comparison to a physician's office visit average of $10, lower utilization of emergency services in favor of office based physician's services would not only save the Medicaid program money, but also would probably result in better quality care for the recipients. Therefore, BS/UR, as part of its hospital services study, is working with hospitals to get them to provide emergency visit records to primary care physicians.

Another technique which can be used to examine utilization is patient profiling. The MMIS is capable of generating patient profiles and Explanations of Medical Benefits (EOMB). In March 1976 a pilot test of EOMBs was conducted. This consisted of mailing EOMBs to the 20,000 recipients in Franklin County. (As of April, responses had been received from 1944 recipients; 185 indicated that they had not received the services described.)

The BS/UR staff reviews the patient profile to identify problem cases. To date the relatively simplistic technique of reviewing those recipients with the highest utilization of services has been used. However, the lock-in system being tested in Franklin County demonstrates that the DPW is attempting to deal with the recipient abuse problem.

BS/UR has made an effort to identify recipients who are over-utilizing medical and pharmaceutical services; in particular, they are identifying those patterns of over-utilization which indicate that a recipient has seen an unusually high number of doctors and/or received a large number of prescriptions which they then had filled in several pharmacies. For the pilot program in Franklin County a sample of such recipients has been identified and procedures put into effect to require each recipient to select one primary care physician and one pharmacy from which he must receive all his medical care. Selected recipients were informed of these procedures through the County Welfare Office. Each recipient was called in for a conference where a representative of the Medicaid program, a social worker, and a fraud investigator were

present. Every attempt was made to explain to the recipient that they were concerned for his health, and that doctor and/or pharmacy shopping may result in receiving medications which duplicate or conflict with those he is already taking and result in increasing rather than decreasing health problems. Recipients were told they may use the doctor and pharmacy of their choice, but must continue to see only those providers until they notify the program of their desire to change providers. While participation in this program is voluntary, all recipients contacted at this point have agreed to participate.

While the main purpose of "locking in" the recipient to one provider is to control recipient abuse, it may also impact provider overutilization and unnecessary referral. In the Franklin County pilot program all recipients selected for the demonstration project were receiving most of their services through a high volume Medicaid clinic. Once a recipient named a physician in the clinic, the physician was informed of the recipient's status in the "lock-in" program and told that all services received by that recipient were to be carefully reviewed. Through this system the provider is also put on notice that the State is carefully watching for unnecessary utilization.

Coordination of Benefits. The Third Party Resources Section was established within the Division of Data Services in February 1976. At the time of the visit it had three staff members and four vacant staff slots. In the period between late February and mid-June 1976, this unit collected $120,000. When this unit reaches full operation, it is likely that substantially more can be collected each year.

The unit has an interesting short history and positive record. Based on the experience of other states (particularly Michigan), Ohio determined that it was probably missing a sizeable recovery potential in the third party area. However, the Department's budgetary problems precluded any new major program activity. Therefore, one investigator with a background in benefits was hired to work on "third party claims." He visited Michigan and gathered information from other states. However, the Department's budget constraints required that the benefits of having such a program be demonstrated immediately. He achieved this by first

turning his attention to ambulance claims looking for potential insurance liability cases. Based on this experience, Ohio has taken a pragmatic and generic approach to third party claims. The definition of third party claims for purposes of Ohio's program is the identification and collection of any funds owed the Department not already addressed by some other part of the Department. Using this definition the Department was able to immediately begin collecting funds without having to go through a time consuming and costly start-up process before any recoveries were actually made.

Upon reviewing the Department's position with respect to third party claims, two immediate deficiencies were noted. First, the Department did not have subrogation authority. A bill was introduced in the Spring 1976 session of the legislature and passed (see Appendix VII). This law allows the Department to collect directly from insurance companies or other "third parties" funds which the Department had previously paid to a provider on behalf of an eligible recipient, but for whom the third party had legal payment liability ahead of the Department.

The second area of change brought about by the Third Party Resources Unit demonstrates its generic approach. The unit noted that by virtue of medical diagnosis a potentially large number of AFDC recipients were eligible for Supplemental Security Income benefits. Although such AFDC recipients, if transferred to SSI, would continue to receive assistance under the Meeicaid program, their cash assistance, paid by SSI, would result in a savings to the Department. A memorandum from the Director describes the new process which has been instituted to identify potential SSI beneficiaires and refer them to SSI. This memorandum is presented in Appendix VIII.

A third activity of the Third Party Resources Unit is to coordinate with County Welfare Offices in terms of medical benefits paid on behalf of AFDC recipients found to be ineligible. When a County Office determines that an ADC recipient has been ineligible and is taking action to recoup funds paid to the ineligible, the County makes an inquiry of the Third Party Resources Unit as to the cost of medical services provided by DPW

during the period of ineligibility. Third Party Resources checks the claims history file and provides this information to the County for collection along with AFDC overpayments. The Third Party Unit chief is empowered to negotiate the amount payable and the method and schedule of payments in conjunction with the County on behalf of the Medicaid program.

The major obstacle to coordination of benefits at the time of the visit was the State court's interpretation of the workmen's compensation legislation. Currently, Third Party Resources has established a good working relationship with Bureau of Employment Services and has informal access to BES information. However, according to the prevailing legal interpretations the BES information cannot be used against a recipient. This means that, although DPW may know a recipient is receiving compensation from BES, they must find a source other than BES in order to be able to use the information.

In summary, the key functions in the area of recipient fraud and abuse control conducted by Ohio include:

- lock-in demonstration program
- coordination with county welfare offices for recover of medical assistance funds from ADC ineligibles
- increased attention to and new procedures for identifying and referring possible SSI cases currently ADC recipients
- use of the new subrogation authority to collect repayments directly from insurance companies and other third party sources

IV. AGENCY FRAUD AND ABUSE CONTROL

The internal agency monitoring function theoretically exists in the Internal Audit Section of the Bureau of Fiscal Review. In fact, this unit has never been staffed and no ongoing program of internal audit exists. However, within the Bureau, the County Audit Unit does audit the county offices and make suggestions as to management procedures which might improve program security. At current staffing levels, the audit cycle is approximately 18 months with each of the 88 counties having been audited once in the period January 1975-June 1976.

The Director of the Bureau of Fiscal Review commented that in a county administered program such as Ohio's the greatest potential for fraud by state employees is in the audits unit where auditors are making rate determinations for hospitals and nursing homes. To date there have been no detected cases of fraud by audit staff, but the Bureau Director has taken no extraordinary steps to prevent or detect such situations.

The second potential area for employee fraud is in automated data processing. To date there have been no identified cases, but the Director of the Division of Data Services expressed concern over this issue. A policy memorandum in this area which is intended as the first of a series on this issue is presented in Appendix IX.

V. BEST PRACTICES

A. Introduction

As noted previously, the purpose of the site visits and these reports was to identify and document practices and procedures in the apparently "good" states which might be of benefit to other states. Therefore, the critical element of a best practice is its transferability or replicability. This section is written to describe those practices in Ohio which appear to be of benefit and to discuss under what circumstances they can be replicated beneficially. Necessarily, the assessments are based in large part on the evaluation of the state involved as to their benefits and the analyst's knowledge of their potential benefit in other states. We have taken a generic approach to best practices and, therefore, include both very specific items and very broad based approaches, such as MMIS. From these individual state reports the best practices will be compiled and analyzed in a final best practices analysis. Therefore, each state report is rather like a "laundry list" from which the final analyses can be performed. Although some best practices exist in more than one state (such as the MMIS) they are discussed in each state report where they represent a best practice.

B. The Ohio Medicaid Management Information System

The MMIS was initiated in Ohio in September 1972 and was certified as fully operational by DHEW in April 1976. It is one of eight states certified as operational as of the Spring of 1976. At the time of the visit the MMIS was processing approximately 1.5 million claims per month with the average turnaround time for claims payment being 76 days from date of service and 29.7 days from receipt of the bill by DPW. The first obvious benefit of the MMIS is that "factoring" is not beneficial to providers in a state where claims are being paid so expediously.

Ohio DPW has centralized automated data processing for all programs in the Division of Data Services. The organization chart for this division is displayed as Exhibit V-1. A total of 265 staff are employed by this Division and the Division uses the State Data Center through a remote job entry system.

The use of the State Data Center has several key aspects:

- availability of time on the machines;
- accessibility in that the Center is located in the same office tower with DPW; and
- Compatible and easy data exchange for other state agencies such as the State Auditor's office who have legitimate need for access to the DPW records.

The Director of Data Services speaks highly of the organizational structure of his division. Key elements of this structure are:

- Invoice Processing - "production shop" that focuses on getting claims paid in a timely fashion without other distractions or responsibilities.
- Provider Assistance - In most other states this function is not co-located with the claims processing function. In Ohio this unit has two primary functions—answering provider inquiries (either written or telephoned) and providing education or training to provider groups about claims processing.
- Systems Design and Programming - this unit does not have line responsibility for claims processing and can, therefore, focus on systems maintenance and improvements and is available to work with other DPW staff, such as BS/UR, to design new programs and reports that continually improve the usefulness of the system.

Dept. of Public Welfare

Div. of Data Services AS OF 7/76

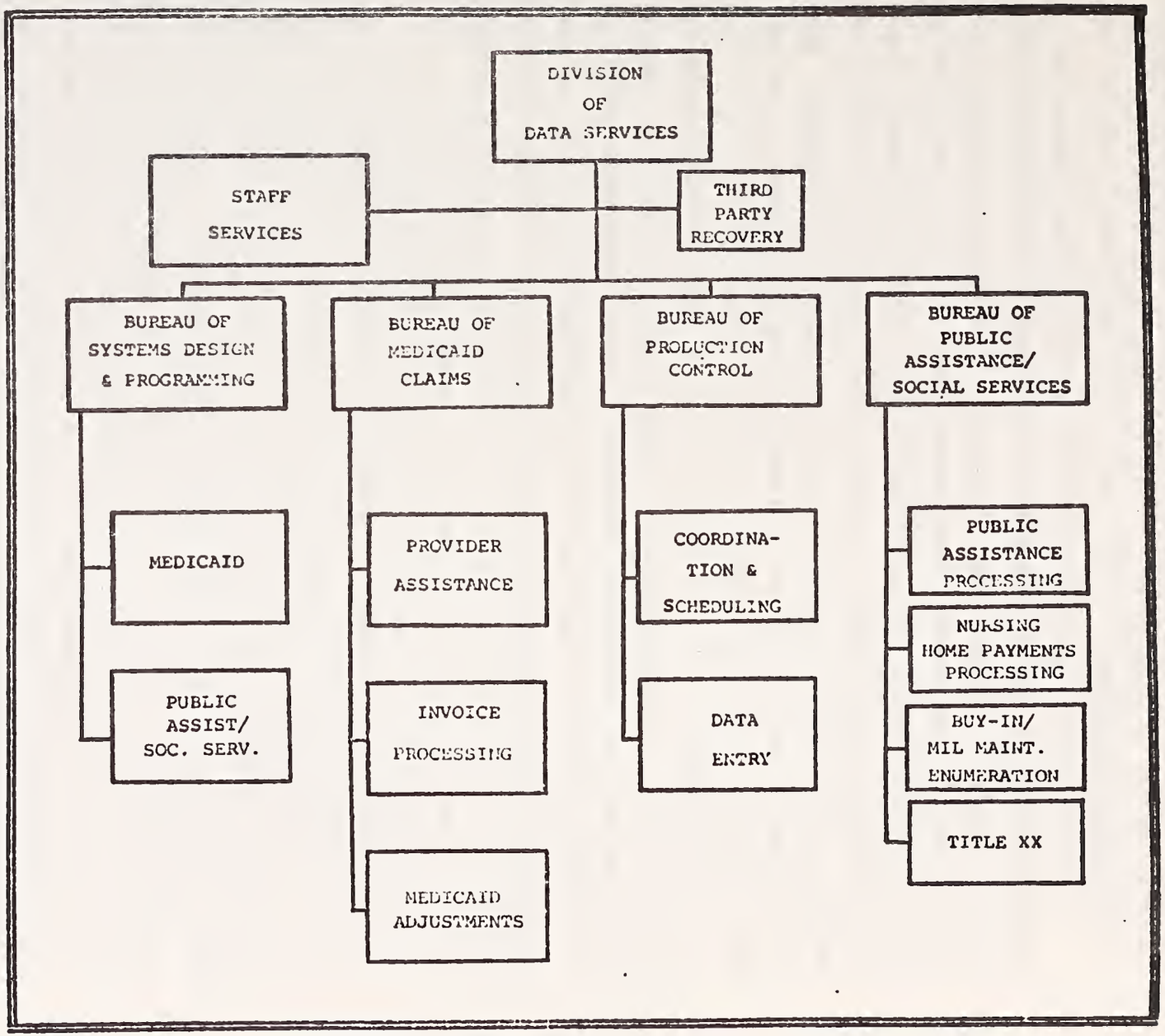


Exhibit V-1

- Third Party Resources Unit. Since it is not directly a part of the MMIS, the function of this unit is addressed separately as a best practice.

1. Provider Assistance

Ohio made Provider Assistance part of the claims processing operation since initially 50% of the claims submitted would not process through the MMIS. It was critical, therefore, with the initiation of the MMIS to provide a great deal of assistance to providers so that providers would not become alienated and so that a major backlog of unpaid claims did not hamper future system operations. Over the years the size of this unit has been reduced in proportion to the need for its services. Part of this unit's services is a toll-free line that providers can use to make inquiries concerning claims problems.

The existence of a provider assistance function as an integral part of claims processing appears to be a valuable practice in expediting claims payment and is probably a critical element during the initiation of an MMIS. Staff who understand the claims processing system, and have immediate access to claims records can provide efficient feedback to providers with correct information and can forestall many problems at the earliest possible stages. However, to be effective this function must be clearly defined and operational. Either the function must be limited to claims processing problems or it must also be fully integrated with the other provider interface functions within the medicaid program such as policy interpretation. Whether a state opts for multiple provider assistance contact points (claims problems, policy problems, audit/rate problems, etc.) or it opts for one large provider assistance unit responsible for provider assistance in all of these areas, it is mandatory that there be effective coordination among the various units involved since inevitably more than one of these functions will be involved in a single problem.

2. Reports

Since Ohio was one of the initial states to begin development and routine use of the MMIS and its report capabilities, its experience may be instructional to other states using the MMIS.

a. Ohio generates provider reports on a quarterly basis and recipient reports every six months.

Ohio has 19 staff members in the BS/UR units and has learned that any more frequent generation of the summary reports inundates the BS/UR staff. Secondly, the Ohio staff finds that with this staffing level, a provider must "except" for 3-4 quarters before the investment of staff time is warranted to review this provider. Ohio uses two standard deviations as the exception criteria and feels it is highly likely that a unique circumstance that does not represent a problem will make a provider except for only one or two quarters. The problem providers will continue to except into the third and fourth quarters. Therefore, from each exception report (2500-3000 exceptions/qtr.) only those providers showing a 3-4 quarter exception history (approximately 600/qtr.) are flagged for further review.

This is only reported as the workload standard adopted by this state and not necessarily as a best practice since there are obvious problems with such a standard. However, states just implementing the MMIS should be aware of the amount of work the MMIS generates for staff responsible for using the reports.

b. Ohio no longer uses the treatment analysis report to any significant extent.

Ohio BS/UR staff have found this report not to be particularly useful and have essentially stopped using it. It should be noted that Michigan which also has a relatively developed MMIS is not using the treatment analysis report format. Based on these two examples, the value of installing the treatment analysis capability should be carefully assessed by each state. Criteria include the focus of the state's program, the skills and availability of review staff, etc.

c. Special Reports/Report Writer Capability

The Ohio BS/UR staff use this capability extensively and find it of great value. This should be assessed in light of the project approach used by the BS/UR staff as discussed in the previous section on investigation.

d. Availability of Reports

It must be kept in mind that for any reports to be of great utility they must truly be quickly available when ever necessary. The end product of the MMIS is not the summary reports per se since each summary report should generate multiple requests for individual reports such as profiles and histories or special reports.

The organization of the single state agency and the organizational relationships of the data processing staff to the report users is a key variable in this process. The Ohio organizational model is one which provides for a tightly run data processing organization which conducts its primary function, claims processing, with a high degree of efficiency. However, the users of the MMIS capability (as distinguished from the users of any good claims processing operation) are the staff using the output reports. Therefore, it is critical that the users be identified as such and have some control over the availability of the reports they require.

3. Beyond the MMIS

As evidenced in Ohio and other states, the MMIS is an efficient and effective system for processing claims, preventing payment of certain types of claims, and generating standard output reports. However, as with all computer systems, the MMIS also provides the capability and incentive for even more advanced services. Ohio has already implemented additional programs for augmenting the basic MMIS capability. The most notable of these is a program designed to readily identify prescription splitting. As noted previously, within the Division of Data Services, there is a unit for Medicaid Systems Design. Although this organizational model may not be the most useful in all circumstances, all parties should recognize that the MMIS should not remain a static system because the number of schemes which the system should be able to assist in preventing and detecting will continue to multiply. Both the front-end edits that will prevent payments and the reports which assist in detecting fraud and abuse should be continually updated and modified.

C. Project Approach to Surveillance and Utilization Review

The systematic "project approach" to surveillance and utilization review, as used in Ohio, is the most developed approach observed in any state. (see section D. Investigation) Ohio has been faced with a level of staffing for utilization review below that desired by the Department. The BS/UR manual references five "health care specialty units" in addition to medical and legal consultants and field investigators. In fact the Bureau of S/UK has two teams each staffed with a supervisor, five analysts, two field investigators and a secretary. With an MMIS reporting 2500 exceptions per quarter, this represents 250 exceptions per analyst per quarter. Even when reduced to 600 "cases" or those exceptions deemed worth pursuing beyond initial screening, this represents an unrealistic workload for the BS/UR analysts. At this point it should be noted that "analysts" are neither health professionals or individuals with investigative backgrounds.

Faced with these two limitations, not necessarily atypical and to some extent beyond the agency's control, Ohio has developed a well-defined and useful management approach for distributing workloads, assigning priorities and monitoring staff performance. The basic elements of this approach are:

- grouping "cases" by provider type, or some other categorization which allows the study of multiple providers within one framework.
- defining the "study" in terms of techniques to be used, sample size, deadlines, and staff resources to be utilized.
- assigning a deadline at which point results to date can be evaluated and further "phases" of the study can be determined.

This approach far exceeds the benefits to be gained from merely dividing the BS/UR workload by provider type. A few of these benefits are as follows:

- staff can become specialized in a particular area or areas and not have to have a familiarity with all provider types and problems;
- the study plan provides a measure against which staff work can be monitored;

- The work for the unit can be prioritized and assigned based on the studies in progress;
- staff can receive a sense of accomplishment as a study or phase closes although the case may be in process for a longer period of time.

Thus, the project approach is not merely a workload distribution tool, but also a performance monitoring, personnel management and scheduling tool.

The reader should be aware that the project approach is not an investigation technique which lends itself to situations where either fraud prosectuions or even administrative sanctions against individual providers are a desired outcome. This technique results in more general outcomes by defining the pattern of abuse and can, in some circumstances, identify the characteristics of the problem (high volume providers only, non-health department licensed laboratories, etc.).

The responses the single state agency can make to the results of such a study include:

- strengthening existing regulations or adding new regulations;
- providing additional provider education in areas being misinterpreted by providers;
- adding new front-end edits or special reports to prevent the problem or detect it more readily;
- launching special investigations of specific providers where the study has shown the real possibility of high dollar fraud to occur; or
- working with professional associations, licensing bodies, or peer review groups when extensive quality of care or ethical issues appear to exist.

The nature of the project approach and its sampling procedure is that no one provider is "investigated" in depth, although the study results may suggest that a particular provider be studied in more depth or investigated per se. While the study approach may include visiting the provider's office, reviewing his records, etc., it typically does not go into the level of detail necessary to prove any given provider's "intent" or to document a criminal case. However, some amount of restitution owed to the Department may be identified through this process.

Therefore, the project approach represents a management tool which can be used to conduct one of the many functions required of a well-balanced approach to fraud and abuse control.

D. Outside State Agency with Independent Authority

The State Auditor who is elected in Ohio has independent responsibility for monitoring Department expenditures and financial procedures. The Auditor also has authority to audit providers in the Medicaid program to assure that correct payments were made.

Several other state reports describe various organizational relationships between medicaid single state agencies and other state agencies and the benefits of locating certain functions within or outside of the single state agency.

In the case of Ohio there are several general points to be made concerning the role of a State Auditor with independent authority.

First, single state agencies must always be sensitive to the complaints of providers and the level of provider participation in the program. This is a very real concern in states like Ohio where fee schedules have not kept abreast of prevailing costs and the reimbursement rates are a negative incentive to provider participation.

Whether justified or not providers can perceive that field visits, audits and other reviews constitute an unnecessary degree of harassment by the medicaid program of a provider already taking less than his usual fee for services to medicaid recipients. Therefore, the conduct of some functions, post payment auditing being an example, the single state agency may have less difficulty in maintaining its necessary relationships with providers if an "outside" agency performs the function. This is not to recommend that in Ohio, or any other state, the single state agency should not conduct audits, but rather that SRS and the states should carefully consider how organizational relationships impact the program in various areas.

The more negative argument for an independent audit agency is that due to concern for provider sensitivity and other reasons, single state agencies may not pursue this function as aggressively as an independent agency.

Secondly, the post payment audit function when conducted by an independent agency serves as an evaluation of the payment procedures of the single state agency. Often, an outside agency can take a management audit approach and suggest improvements to the single state agency's procedures. The voice of an outside agency supporting the single state agency's request for additional funding, staff, etc., can add great credence to the case presented by the single state agencies.

Thirdly, the reports of an audit agency are often a matter of public record whereas agency documents may be considered privileged. Once again, release of a report by an audit agency may serve the single state agency's purpose while the single state agency is blameless in the eyes of the provider or other groups. The presence of an outside agency also makes it more difficult for a single state agency to hide its internal problems.

Finally since a major function of a state auditor is to serve as a collection agency for the state, the auditor usually has in place accepted and efficient procedures for recouping funds. Such procedures may include an established liaison with the State Attorney General for filing civil recovery actions. Since the primary function of single state agencies is disbursing rather than collecting funds, greater use of other state agencies for collection purposes might be more efficient and prevent duplication in some circumstances.

To summarize, the State Auditor in Ohio is one example of a case where another state agency could perform some functions in conjunction with the single state agency with positive benefits for the medicaid program. It must be reiterated that "in conjunction with" are key words since sharing or delegating functions to other agencies can lead to competing agencies, or buck passing as to who is responsible so that no one performs the function and, therefore, the circumstances in each state must be evaluated carefully as to the value of dispersing functions across agencies. Also "auditing" comprises many tasks and Ohio performs auditing functions within the single state agency which are separate and distinct from those performed by the State Auditor. Therefore, the components of a function must be carefully analyzed in terms of who can best accomplish them.

E. Third Party Recoveries

Third Party Recoveries is a relatively new function in most states and the benefits demonstrated in states which have a third party recovery unit make the existence of such a function a best practice in and of itself. Ohio demonstrates two practices which warrant further discussion as best practices.

First, third party recoveries is defined very broadly in Ohio and this state has already collected a significant amount of funds ($120,000 in five months) although a relatively small amount of this is from traditional third party sources—insurance companies. Ohio has defined "third party" as any one who potentially owes the Department money and is not being addressed by some other part of the Department. There are two good examples of this:

- recipients involved in accidents where ambulance services were involved (detection technique) and some one else was responsible and, therefore, liable for paying the recipient's medical costs. Since automobile accidents, for example, can involve long lengths of stay, surgery, and other costly services, each such claim for which recompense is received from the liable third party may result in sizable savings to the program.
- recipients of cash grants who are potentially eligible for SSI. Since certain diagnoses represent almost automatic eligibility for SSI, the Ohio Third Party Resources Unit reviews claims by diagnosis to detect these cases. (For description of procedures see Section III.3. Cordination of Benefits). This is an example of the broad definition used by Ohio since the transfer of a recipient to SSI would not save Medicaid dollars, but would save cash grant funds. Since caseworkers determining eligibility are primarily trained in determining the recipient's financial status and not medical status, this represents a single check on the eligibility determination system.

The broad definition used by Ohio demonstrates that states should not take a limited view of the potential sources of recovery which leads to the second point - how to set up a third party recovery unit.

The Ohio DPW during FY 76-77 was in a very constrained financial position to the extent that the payment of claims had to be suspended for

a temporary period due to lack of funds. Yet, in this situation it managed to set up a third party recovery unit. Furthermore, Ohio DPW had no subrogation authority and, therefore, could not directly approach health insurance carriers for reimbursement. This situation is not unique particularly to the extent that not many states have extra funds to begin new activities. The fact that Ohio started a program in such circumstances is exemplary. Key elements of the Ohio approach include:

- the selection of a dynamic individual, committed to the concept of recovery and experienced with insurance and investigation matters. In the case of Ohio, the person selected had been a senior medical underwriter knowledgeable in both health insurance and workmen's compensation.
- targetting work to be able to demonstrate results in the time frame required. In Ohio there was extreme necessity to show results quickly. Therefore, since establishing procedures for recouping from health insurance carriers and workmen's compensation is going to take a relatively long time to show results, the unit started with more likely sources such as liability cases.
- selecting work techniques which fit the requirements for results. Although the Ohio MMIS has great capability, the third party resources unit opted for an easy manual system for identification of potential sources. This manual system works to the extent that results can be demonstrated while the computer programs necessary to support the effort are being developed. In this case all ambulance claims were pulled by claims processing upon receipt and manually reviewed by third party staff for potential liability cases. Claims of interest were photostatically copied and all claims returned to claims processing so that essentially no delay in the payment of claims occurred. While time consuming and probably not suitable over the long term, this technique worked to meet the immediate objective of identifying potential cases and achieving recoveries.
- analysis of the tools needed to be effective and efficient over the longer term and starting to gain those tools. Subrogation authority is a critical element in the efficient recovery of funds. Ohio immediately identified this as a missing tool and began work with the legislator to have that authority added to the state welfare statute. In this case that tool became available about four months after the third party unit had come into existence and had established

momentum, experience and added a few more staff people. Thus, the tool became available at about the time the unit was really ready to begin using it.

- placement of the third party recovery unit within the organization in the location most likely to expedite its work.. In a number of states, third party is placed with the program integrity or compliance units such as S/UR or investigations. This is often useful since there is some relationship between third party recoveries and program abuse and investigation techniques are required for both. However, Ohio placed this unit within Data Services. In Ohio this is very efficient since it provides immediate access both physically and organizationally to the claims data required to identify cases. It should also facilitate the development of the programming which will be required in the longer term to support this function.

While Ohio is instructive with regard to establishing a new third party recovery unit and showing short-term results, it must be remembered that to achieve the larger dollar recoveries ($20-30 million per year) a fully operational system is required. Like surveillance utilization review units whose efficiency and effectiveness is significantly enhanced through the MMIS, third party recovery units must also have computer support to digest the large volume of claims that must be reviewed to identify the cases where recovery is possible. While in the short-term dynamic staff, manual review of claims, etc., will show results, it is estimated that only 10-20% of the potential recoveries can be achieved without computer support and strong management systems. Along with these two factors, negotiations with other payors, establishing working relationships and clarifying legal positions are required to achieve fully operational status.

- Matching funds are not available for support of the welfare auditing staff within the state auditor's office. While it can be argued that this is a state function independent of the medicaid program, it is clear that the state auditor is supplying assistance to DPW to compensate for lack of manpower in the Department.

  It is not entirely clear that the match provisions are being interpreted and utilized uniformly across the country.

- The experience of Ohio is similar to other states in that while the MMIS is a very productive prevention technique per se, the system also generates a great deal of data which requires manual analysis. It can be argued that since the MMIS is not effective as a detection technique if qualified staff is not available in sufficient number to effectively use the subsystem reports, an increased match ratio should also be available for S/UR and investigations staff.

Appendix I

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

STATE OF OHIO ATTACHMENT 4.19-B

Methods and Standards for Establishing Payment Rates

1. Inpatient Hospital Services

Providers are paid the reasonable cost of services provided to Medicaid beneficiaries. Hospital billings must reflect the hospital's customary and reasonable charge for the services rendered. Interim payments approximating the allowable costs established by the providers prior cost filings are made in the most expeditious manner which is administratively feasible.

An interim adjustment based on allowable costs are made after the end of the reporting period on a first-in-first-out basis. All cost reports and settlements are considered interim until notified by the Ohio Department of Public Welfare, Bureau of Fiscal Review.

The principles and standards contained in the "Provider Reimbursement Manual" HEM 15, are to be used by providers in accumulating cost data for the Annual Reporting Forms DPW 2220.

2. Outpatient Hospital Services

Same as the method described for inpatient hospital services.

3. Other Laboratory and X-Ray Services

Payment for laboratory and X-ray service is made on the basis of the providers customary and reasonable charges up to the 75th percentile established for the particular service rendered. In no instance may the payment exceed Medicare reimbursement for the same services.

4a. Skilled Nursing Facility Services for Individuals 21 Years of Age or Older

Payment for authorized care in certified facilities (including public facilities) is calculated on a "prospective reasonable cost related basis" from cost reports filed by each participating nursing home. The per diem is calculated on a facilities' cost and thus varies from facility to facility. Payments to a certified skilled facility are for skilled care; payments to dual certified SNF and ICF facility are the same for Skilled Care and for ICF care; payments to certified ICF facility are for ICF care.

Prospective

Prospective rate refers to a "fixed" (cost related) fee calculated for each facility from that facility's cost report. The rate thus established is not subject to a subsequent, retroactive settlement except in situations involving misrepresentation of costs and/or services rendered, or concealment of a lower rate than currently being paid. An example of the latter would be failure to file a cost report within ninety days of the end of the reporting period.

Reasonable Cost Related Basis

The factors used to establish the reasonableness of expenditures which comprised the prospective per diem are as follows:

1. Costs incurred for the care, comfort and safety of patients provided they do not exceed ceilings established for the following administrative expenditures. The cost for patient care, comfort and safety does not include the amount for property or equipment and interest paid on loans to finance or refinance such property or equipment. Also not included is the cost of prescription drugs, physician services and medical services of limited practitioners (such as physical therapists, psychologists, dentists, etc.) as these costs are met by direct payment to these providers.

   The following variable ceilings have been established for each category of cost. The amount recognized in calculating the prospective rate is the facility's reported cost or the ceiling--whichever is less.

. Administrative Personnel Expenses -- The maximum allowable (1) as owner compensation for duties which otherwise require the employment of another individual, (2) for an administrator or (3) for an assistant administrator is computed according to a formula. The formula uses a base salary range (which varies according to bed size) to which percentages are added for certain factors. The result obtained or the maximum upper rante (whichever is less) is allowed. The "factors" for which percentages are added to base salary range are:

- Work Experience --four percentage points for each year of related work experience up to a maximum of ten years.

- Education -- five percentage points for each year of formal education up to a maximum of six years if a BA degree has been obtained, or up to a maximum of four years if a BA degree has not been obtained.

- Performance of other duties -- four percentage points for each duty not ordinarily considered as part of the responsibility of the position up to a maximum of four additional unrelated duties.

If, however, any of the duties claimed is also jointly done by another individual, the percentage points added are offset by "negative" points. The number of negative points varies according to the size of the facility (e.g., 1-24 beds, 20 negative points; 24-49, 15; 50-74, 10; 75-100, 5; and 101 and over, 0).

- Geographic Location -- percentage points (ranging from eight in rural to fourteen in urban) are added for the county in which the home is located.

. Nursing Services (RN, LPN, Orderlies, Aids, etc.) -- the maximum allowed for professional nursing services and other nursing services is

- Median hourly wage in each area (but at least 20% above the minimum hourly salaries) multiplied times

- Minimum staffing requirements necessary for licensure and/or certification.

. Occupancy Limitation -- The facility's average occupancy rate or 85% occupancy rate (whichever is greater) is used to calculate the indirect or fixed cost of a facility. Indirect or fixed costs are those which do not vary with the number of patients served.

. Other Limitations -- The maximum allowed for other expenses is at least the ninetieth percentile as determined by a sample of cost reports filed with ODPW of those expenditures.

The ninetieth percentile limitation applies to cost such as food, and supplies, travel, advertising, maintenance, repairs, other administrative personnel, houskeeping and laundry personnel. The ninetiety percentile limitation does not apply to license dues, employer share of taxes, etc., insurance, and utility costs--all of which are recognized in full.

2. Cost of property and equipment and related interest expense is reimbursed on a fixes basis as follows:

. Facilities (including beds within such facilities) constructed prior to and subsequently originally licensed prior to 1958 - $2.50 per available bed per day.

. Facilities (including beds within such facilities) constructed and subsequently originally licensed after 1957, but prior to 1968 - $3.50 per available bed per day.

. Facilities (including beds within such facilities) constructed and subsequently originally licensed January 1, 1968 and after, $4.50 per available bed per day.

This payment is in lieu of reimbursement for depreciation in property plant and equipment, taxes, interest and/or rent.

3. Profit allowance equal to ten percent of cost incurred for care, comfort and safety of patients not to exceed $1.50 per patient per day. The profit allowance does not include cost attributed to

. Property, equipment and related interest expense (fixed cost) referred to in number 2 or

. Return on salaries attributable to owners' services.

Cost Differential Between Payments Made to Skilled Nursing Facilities and Payments Made to Intermediate Care Facilities (45 CFR 250 (b)(3)(iii)

The minimum ten percent cost differential between payments made to skilled facilities and payments made to intermediate care facilities will be computed on an aggregate, statewide basis based upon the total payments made to a skilled facility certified for skilled and/or ICF services and the total payments made to facilities certified for ICF services only.

. The statewide average per diem amounts paid for skilled nursing facility services include

- Payment for skilled care in facilities only certified to provide skilled care, and

- Payments for both skilled and intermediate care in facilities certified to provide both types of care.

. The statewide average per diem amounts paid for intermediate care facility services will include payments for intermediate care in facilities certified for ICF care only.

It is anticipated that the cost differential will be obtained as a result of the inherent difference in the cost of the two types of facilities. However, since payments are based on each facility's report of cost, a waiver of the differential requirement is requested in the event the State's quarterly expenditure report does not reflect at least a ten percent per diem differential. The reasonableness of such a waiver request is apparent because of the State's calculation of per diem (i.e., reasonable cost related formula based upon each facility's cost).

4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found

Payment is based on the customary and reasonable charges of the individual providers found elsewhere in this schedule.

4c. Family Planning

Payment is based on the reasonable and customary charges according to the type of provider and services rendered.

5. Physician Services

Payment is based on the providers customary and reasonable charges up to the 75th percentile established for the particular service rendered. In no instance may the payment exceed Medicare reimbursement for the same services.

6. Other Types of Remedial Care

a. Podiatrist Services

The Medicaid Program reimburses the provider the least of the following:

1. the billed charge
2. the reasonable and customary charge for the same service under Medicare
3. the Medicare prevailing charge in his locality
4. The Ohio Department of Public Welfare maximum payment schedule for that service

b. Optometrist Service

The payment is based on the reasonable and customary charges up to the 75th percentile established for the particular service rendered. In no instance may the payment exceed Medicare reimbursement for the same services.

c. Chiropractic Services

The payment is based on the reasonable and customary charges up to the 75th percentile established for the particular service rendered. In no instance may the payment exceed Medicare reimbursement for the same services.

d. Mechanotherapist Services

The payment is based on the reasonable and customary charges up to the 75th percentile established for the particular service rendered. In no instance may the payment exceed Medicare reimbursement for the same services.

e. Chiropractor and Mechanotherapist

The payment is based on the reasonable and customary charges up to the 75th percentile established for the particular service rendered. In no instance may the payment exceed Medicare reimbursement for the same services.

f. Cosmetic Therapist

The payment is based on the reasonable and customary charges up to the 75th percentile established for the particular service rendered. In no instance may the payment exceed Medicare reimbursement for the same services.

7. Home Health Care Services

a. Intermittent or part-time nursing service furnished by a home health agency.

Usual and customary reasonable charges are paid for services up to a limit of $20.00 per visit. In no instance may this reimbursement exceed the amount paid by Medicaire.

b. Intermittent or part-time nursing service of a professional RN or LPN when no home health agency is available.

Payment is based on the customary and reasonable charges which are made in the community for the nursing services rendered

c. Medical supplies, equipment and appliances for the patient's use in his own home.

Payment is based on customary and reasonable charges not to exceed the departmental maximum reimbursement. Decisions concerning purchase or rental of durable medical equipment is made by the authorization unit of the Bureau of Medical Operations.

d. Services of a Home Health Aid giving personal care according to a plan or treatment.

Based on the usual and customary charges which are reasonable not to exceed the departmental maximum. In no instance may this be greater than the reimbursement under Medicare for the same services.

8. Private Duty Nursing Services

Payment is based on the customary and reasonable charge. Payment may not exceed the reimbursement made for the same services under Medicare.

9. Clinic Services

Payment is based on the basis of customary and reasonable charges up to the 75th percentile established for the particular service rendered. In no instance may the payment exceed Medicare reimbursement for the same services.

10. Dental Services

Payment is on the basis of customary and usual fee up to the Department's maximum schedule for dental services.

11. Physical Therapy and Related Services

a. Physical Therapy

The basis of payment is the customary and reasonable charge up to the 75th percentile not to exceed Medicare reimbursement for the same type of service.

b. Occupational Therapy

Based on customary and reasonable charges up to the 75th percentile not to exceed Medicare reimbursement for the same type of service.

c. Speech, Hearing and Language Disorders

Services provided by or under the supervision of a speech pathologist or audiologist.

Based on customary and reasonable charges up to the 75th percentile not to exceed Medicare reimbursement for the same service.

12. Prescribed Drugs, Dentures, and Prosthetic Devices and Eyeglasses

a. Prescribed Drugs

Payment to the pharmacist is as follows:

LEGEND DRUGS. The upper limit for legend drug prescriptions is the average wholesale price as contained in the Drug Topics Red Book, plus a professional fee of $2.00. Payment for legend drug prescription services is on the basis of the pharmacist's billed charge or the AWP price of the drug plus a $2.00 professional fee, whichever is the less. The billed charge should be the pharmacist's charge paid by the general public for similar services, including billing charges, family prescription, delivery charges, and other pharmaceutical services.

NON-LEGEND OVER-THE-COUNTER DRUGS. Payment for non-legend over-the-counter drugs will be on the basis of the pharmacist's billed charge, or the average wholesale price of the drug plus a 50% markup, or AWP plus $2.00, whichever is less.

b. Dentures

Billing is according to the practitioner's usual and customary fee. Actual reimbursement is based on a fee schedule developed by the Ohio Department of Public Welfare.

c. Prosthetic Devices

Payment is made on the basis of the customary and reasonable fee for such items, not to exceed the Department's maximum payment schedule for such items.

d. Eyeglasses

Billing for services according to the provider's reasonable and customary charges. Reimbursement is on the basis of the Department's maximum payment schedule.

14b. Services for Individuals Age 65 or Older in Institutions for Mental Diseases

1. Inpatient Hospital Services

Reimbursement is on the basis of reasonable cost for services rendered, not exceeding the Medicare reimbursement rate.

2. Skilled Nursing Facility Services

None designated to date.

3. Intermediate Care Facility Services

None designated to date.

15. Intermediate Care Facility Services - General (Other than Institutions for Tuberculosis or Mental Diseases)

See Section 4(a)

a. Intermediate Care Facility Service - Public Institutions for Mentally Retarded or Developmentally Disabled

Reimbursement to the State Institutions shall be reasonable charges for ICF-MR or other services included in the Ohio Medicaid Program and provided by the State Institutions but not to exceed costs determined in accordance with the principles of reimbursement for provider costs under Part A of Title XVIII of the Act; effective retroactively to Marcy 18, 1974, as regulated in 45 CFR 250.30(b)(3)(iii)(a).

16. Inpatient Psychiatric Hospital Services for Individuals Under 22

Reimbursement is the same as outlined in Inpatient Hospital Services under Number 1.

17. Any Other Type of Remedial Care, etc.

a. Transportation

Payment is made on the basis of the customary and reasonable charge up to the Department's maximum reimbursement schedule for such services.

c. Care and Services in Christian Science Sanitoria

Payment is the same as it is in any ICF admitting the general geriatric or disabled patient. Both Christian Science facilities are certified as ICF's.

d. Skilled Nursing Services for Patients Under 21

Payment is the same for patients under 21 years of age as it is for an individual over 21 requiring skilled nursing care.

e. Emergency Hospital Services

Payment is made on the basis of itemized charges for services rendered.

Appendix II

PREPAYMENT CHECKS

STATE OF OHIO

MEDICAID MANAGEMENT INFORMATION SYSTEM
DETAIL DESIGN DOCUMENTATION

DATA ELEMENT DEFINITION

DATA ELEMENT NAME		DATA ELEMENT NO.
Error Codes		384
ORIGINATING SUBSYSTEM	**COBOL PICTURE**	**REVISION NO**
Claims Processing	Occurs 10 Times XXX	
SYSTEM MNEMONIC		**FILE CONTAINED IN**
CLAIM-ERROR-CODE		Transaction Files
SOURCE OF DATA ELEMENT		
Computer generated at various processing steps.		

DEFINITION

A code indicating a claim transaction has a particular error condition.

CODE	EXPLANATION
ØØ1	Batch Number not numeric
ØØ2	Type of Claim invalid
ØØ3	Number of Document not numeric
ØØ8	Transaction Code not valid
ØØ9	Entry Date not valid
Ø11	Record Type invalid/missing or sequential Type 1 records for Claim Type O, Q, R and W.
Ø12	Document Number not numeric
Ø13	Duplicate line item records
Ø14	No. Line items exceed 25
Ø24	Record is a Crippled Children

Code	
100	Provider Number not numeric
102	Line number not numeric/zero
104	Case Number not numeric
105	Case Number fails check digit audit
106	ADC Number not numeric
108	Batch Not on Control File or previously processed
109	Attending Physician Number invalid
110	Date Prescribed invalid
111	Date Dispensed invalid
112	Supply Code missing
113	Quantity not numeric
114	Submitted Drug/Supply Charge not numeric
115	Amount received from Other Sources not numeric
116	Supplier Processing Code invalid
117	Allowed Drug/Supply Charge not numeric
118	Prescription Number missing
119	Drug Code missing
120	Procedure Code missing
124	Date of Service invalid
126	Submitted Procedure Charge not numeric
127	Procedure Processing Code not valid
129	Third Party Participation not valid-first
130	Third Party Participation not valid-second
131	Third Party Participation not valid-third

Code	
132	Third Party Participation not valid-fourth
133	Third Party Participation not valid-fifth
134	Total Claim Charge not numeric
135	Net Claim Charge not numeric
136	Reimbursement Amount not numeric
137	Place of Service in error
138	Date of Pickup invalid
14Ø	Number of Miles not numeric
141	Rate per Mile not numeric
142	Line Item Charge for numeric
143	Extra Attendent not numeric
144	Attendant Charge per Hour not numeric
145	Attendant Line Item Charge for Time not numeric
146	Other Charges field not numeric
148	Admission Date not valid
151	Type of Service invalid
154	Category of Service not numeric
155	Group Member Provider Number not numeric
156	Tooth Number invalid
158	Fund Type invalid
161	Claim Number of claim to be credit not numeric
162	Credit Amount not numeric
163	Credit Approver missing
164	Claim Number of claim to be adjusted not numeric
165	Adjustment Amount not numeric

Code	
166	Adjustment Approver missing
171	Total Blood Charge not numeric
172	Total Non-covered Blood Charges not numeric
173	Accomodation Days not numeric
177	Total line item charge not numeric
178	Total non-covered line item charge not numeric
179	Surgery CPT not valid
18Ø	Surgery Date not valid
181	Beginning Date of Service not valid
182	Ending Date of Service not valid
183	Type of Bill not valid
184	Leave Days not numeric
185	Reason for Final Bill not valid
187	Discharge Destination Provider Number is missing, not numeric or fails check digit
188	First Procedure Service Date invalid
189	Last Procedure Service Date invalid
19Ø	Admission Date not valid
191	Total Visits not numeric
195	Medicare coverage code Invalid
196	Cash Deductible Amount not numeric
197	Blood Deductible Amount not numeric
198	Coinsurance Amount not numeric
199	Other Charge Amount not numeric
2ØØ	Coinsurance Days not numeric

Code	
2Ø2	Recipient First Name missing
212	Charge per Pint not numeric
213	Patient discharged and destination blank
214	Provider Number fails check digit audit
218	Units of Service Greater than 1Ø
297	Unauthorized procedure on Prior Authorization
298	Submitted Procedure Charge greater than Authorized Payment Amount
299	Claim with no matching Prior Authorization Number
3ØØ	Transaction Code invalid for record (a) 1st digit must be 1 or 2 for record codes A-J (b) 1st digit must be 3 or 4 for record code K (c) 1st digit must be 2 or 3 for record code L
3Ø1	Provider Number not on file
3Ø2	Diagnosis Code not on file-a Diagnosis Code of all zeros is accepted as on file
3Ø3	At least one Third Party Participation Code is not blank and Amount Received from Other Sources is zero
3Ø4	Total Claim Charge less Amount Received from Other Sources not equal to Net Claim Charge
3Ø6	The First Procedure Service Date must not be subsequent to the Last Procedure Service Date
3Ø7	The Last Procedure Service Date must not be subsequent to the Current Date
3Ø8	The Billing Date must not be subsequent to the Current Date
3Ø9	The Place of Service must not conflict with the Procedure Code - see CPT book - 90000 series

Code	
31Ø	The Type of Service must be consistent with the Procedure Code (i.e., if Type of Service is "A" or "S" the Procedure Code must be between 10000 and 69999)
311	Group Member Provider Number not on file - note - check only for first line item; ignore audit for all other line items; also check if number is zero
312	Procedure Process Code is "R" and Allowed Procedure Charge not zero
313	Sum of all Submitted Procedure Charges not equal to Total Claim Charge
314	Drug/Supply Code not on file unless Supplier Processing Code is "F" and Allowed Drug/Supply Charge is not zero
315	Date Prescribed subsequent to Current Date
316	Date Dispensed subsequent to Current Date
317	Date Prescribed subsequent to Date Dispensed
318	Beginning Date of Service subsequent to Ending Date of Service
319	Beginning Date of Service prior to Admission Date
32Ø	Total Claim Charge less Amount Received from Other Sources not equal to Net Claim Charge
321	Blood Furnished not equal to Blood Replaced plus Blood Not Replaced
322	Units of Service not equal to the sum of all line item Accommodation Days
323	Units of Service not equal to the sum of line item Number of Visits
324	For each line item used, Accommodation Days times Accommodation Rate not equal to line item Total Charge
325	For each line item used, Number of Visits times Charge per Visit not equal to line item Total Charge

Code	
326	Line item Total Charge less than line item Non-covered Charge
327	Surgery Code not in Procedure File
328	Date of Surgery prior to Beginning Date of Service or subsequent to Last Date of Service
329	Sum of line item Non-covered Charges not equal to Non-covered Claim Charge
33Ø	Date of Pickup subsequent to Current Date
331	Number of Miles times Rate per Mile not equal to line item Total Charge
332	Hours of Waiting Time times Charge per Hour not equal to line item Total Charge
333	Blood Not Replaced times Charge per Pint not equal to line item Total Charge
334	Sum of all line item Total Charges not equal to Total Claim Charge
335	The Number of Days spanned by the Beginning and Ending Dates of Service must be equal to: (1) If the Type of Bill is interim or final with a Reason for Final Bill of benefits exhausted, the sum of Leave Days and Units of Service (2) Otherwise, the sum of leave days and units of service plus one
336	Sum of Ambulance Line Item Charges not equal to Total Claim Charge
338	Admission Date subsequent to Current Date
339	Start of Plan subsequent to End of Plan
34Ø	First Date of Service subsequent to Last Date of Service
341	CPT Code conflicts with Provider Type
35Ø	Coinsurance exceeds 20% of Total Charge
351	Units of Service for non-visit type procedure is greater than 1

Code	
352	No charge submitted by provider for "by report" procedure with zero price
353	No Prior Authorization for procedure requiring Prior Authorization
354	CPT not compatible with ICDA
400	Non-compatible Sex Codes in procedure and diagnosis records
401	Procedure not paid for claims in this date range
402	Procedure not paid for C. C. Claims
403	Procedure paid only for Crippled Children
404	Type of Service Code is in error
405	Anesthesiology Type of Service and improper Procedure Code - not 10000-69999
406	Drug Quantity is not within minimun and maximum range
407	Drugs not paid for claims in this date range
408	Supply not paid for claims in this date range
409	Supply not paid for Crippled Children
410	Supply only paid for Crippled Children
411	Provider not eligible at time of service
412	Provider not eligible to furnish Crippled Children services
413	Provider has "stop payment" indicator in his Provider File record
450	Authorized Category of Service on Provider Master incompatible with claim
500	No matching Provider Master for Attending/ Referring/Prescribing Physician
501	Category of Service not payable after 4/30/76
502	Must be prior authorized as of 5/1/76
503	Procedure not paid for this Category of Service after 4/30/76
600	No matching Case Record with this Case Number
601	No matching Recipient ADC Set with this Case ADC Number

Code	
602	No matching Foster Care Record for this Case and ADC Number
603	Recipient Master indicates that this claim is ADC
604	Case Name in claim transaction does not agree with Recipient Master Record
605	Recipient Sex Code does not agree with sex indication in Procedure and Diagnosis Records
606	Recipient not eligible during claim period
607	Category of Service and Medicare type codes are imcompatible
608	Prior Authorization does not indicate C.C. claim, but Recipient Master File indicates C.C. only
609	Recipient Master File does not show recipient in nursing Home
610	Hospitalization HI code present. No 3rd party indicators
611	Medical HI code present. No 3rd party indicators
612	Medical and Hospitalization HI code present. No 3rd party indicators
701	Duplicate or conflicting claim
702	90-day hospital day limit exceeded
703	Over 4 visit limit
704	More than twenty claims on a recipient in a processing run
705	Claim Batch Date older than one year
706	Drug Date Dispensed greater than 360 days from Date Prescribed
707	Prescription refilled six or more times
708	First Service Date is more than six-months old.
710	Duplicate Claim Paid under same Control Number.
711	Over 4 different providers in the month
712	Over 10 visit limit including Inpatient Hospital

713	Over Utilization of pre and/or post Natal Care
714	Initial Visit for new patient used more than once
720	Claim outside current History range. To be recycled using full History
XXX	Auditor reject
YYY	Payment calculation equals zero
ZZZ	Calculated Charge greater than Charges Submitted

Appendix III

MMIS REPORTS

C. SUBSYSTEM OUTPUTS

Output Name	Ohio ID	MMIS ID	Page
Provider History Index	HUMR1ØP		VII-474
Provider History Module Process Summary	HUMR15P		VII-478
Management Summary Report: Provider Class Profiles	HUMR2ØP	SU-O-Ø2 - SU-O-Ø8	VII-485
Provider Frequency Distribution Report	HUMR3ØP	SU-O-Ø2 - SU-O-Ø8	VII-525
Summary Profile Report: Provider	HUMR4ØP	SU-O-12 - SU-O-18	VII-532
Provider Summary Module Process Summary	HUMR45P		VII-542
Provider Detail Selection Parameter List	HUMR6ØP		VII-549
Provider Detail Report	HUMR7ØP	SU-O-21	VII-552
Provider Detail Module Process Summary	HUMR75P		VII-600
Management Summary Report: Recipient Class Profiles	HUQR1ØP	SU-O-Ø1	VII-605
Recipient Frequency Distribution Report	HUQR2ØP	SU-O-Ø1	VII-621
Summary Profile Report: Recipient	HUQR3ØP	SU-O-11	VII-627
Recipient Module Process Summary	HUQR35P		VII-637
Management Summary Report: Treatment Analysis Class Profiles	HUQR8ØP	SU-O-Ø9 & SU-O-1Ø	VII-646

Output Name	Ohio ID	MMIS ID	Page
Treatment Analysis Report	HUQR9ØP	SU-O-19 & SU-O-2Ø	VII-660
Treatment Analysis Module Process Summary	HUQR95P		VII-678
Provider Control Parameter List	HURRØ1P		VII-684
Recipient Control Parameter List	HURR1ØP		VII-691
Treatment Control Parameter List	HURR2ØP		VII-698
Report Writer Parameter List	HURR6ØP		VII-701
Report Writer Selection Report	HURR7ØP		VII-717
Requested Special Reports	HURR8ØP	SU-O-22	VII-723
Report Writer Module Process Summary	HURR85P		VII-728

Appendix IV

SAMPLE MMIS SUMMARY REPORT

MANAGEMENT SUMMARY REPORT: PROVIDER CLASS PROFILES
CATEGORY OF SERVICE: 01
AVERAGES & STANDARD DEVIATIONS SECTION
FOR MONTH OF MARCH, 1975
CLASS GROUP: 00

REPORT ITEM/SECTION NO.	TITLE		CLAIMS PAID THIS MONTH	FOR SVC IN AVG. QTR	FOR SERVICES RENDERED TO DATE AS OF: THIS QTR	1 QTR AGO	2 QTRS AGO	3 QTRS AGO	4 QTRS AGO	TREND RATE
01	MASTER EXCEPTION CONTROL SECTION									
01	TOTAL DOLLARS PAID	AVG.	41326.26	43266.81	23625.32	74111.65	67492.86	66354.30	58994.05	-4.70
		S.D.	103160.93	146403.41	45194.15	179875.55	184374.91	188867.92	158899.39	+57.25
02	TOTAL NO OF RECIPIENTS SERVED	AVG.	77.26	71.70	33.77	105.92	110.32	112.41	111.60	-9.12
		S.D.	154.05	186.77	54.71	186.31	229.21	239.11	237.15	+56.14
02	RECIPIENT VOLUME SUMMARY SECTION									
01	NO OF RECIP - MEDICAID ONLY	AVG.	47.13	52.44	32.66	84.38	77.00	78.29	77.01	-3.19
		S.D.	86.23	130.62	46.17	148.17	157.73	157.31	153.59	+55.64
02	NO OF RECIP - MEDICARE	AVG.	42.04	40.71	15.73	32.84	53.96	55.45	55.04	-18.88
		S.D.	86.03	84.28	55.33	68.36	98.29	105.71	106.96	+41.05
03	NO OF RECIP - C.C. ONLY	AVG.	5.24	4.80	1.00	6.34	7.18	8.24	9.76	-27.17
		S.D.	7.90	14.53	0.00	15.11	16.13	20.83	21.45	+54.37
04	NO OF RECIP - C.C. & MEDICAID	AVG.	47.13	51.09	32.66	84.38	77.00	71.30	76.50	-1.70
		S.D.	86.23	126.22	46.17	148.17	157.73	140.11	150.24	+55.96
03	FINANCIAL SUMMARY SECTION									
01	TOTAL AMOUNT CHARGED	AVG.	59369.03	57889.84	26754.86	93633.55	90466.37	91715.95	80601.51	-5.72
		S.D.	134215.48	181727.54	49886.72	210494.80	227826.55	239188.55	202324.56	+56.97
02	AMT PAID - MEDICAID DIRECT	AVG.	42662.33	45337.95	23900.45	75900.41	67757.40	69393.44	60909.28	-0.88
		S.D.	103426.32	147586.03	45247.65	180717.08	181458.38	190266.04	158072.15	+56.38
03	AMT PAID - MEDICARE CROSSOVERS	AVG.	1496.89	1700.64	474.91	1213.09	2106.27	2375.61	2524.98	-22.03
		S.D.	2443.67	2962.49	1392.37	1637.59	3105.78	3731.58	4435.78	+42.31
04	AMT PAID - C.C. ONLY	AVG.	6015.86	5357.83	174.00	8063.00	9620.30	8889.73	8807.07	-23.86
		S.D.	10881.28	17269.83	0.00	19288.69	21984.79	25961.16	20746.36	+53.95
05	AVG PAYMENT PER PATIENT DAY	AVG.	108.23	105.12	111.66	106.27	107.53	98.70	94.73	-1.23
		S.D.	37.61	47.64	37.69	35.34	47.75	40.37	36.17	+54.71
06	AVG PAYMENT PER RECIPIENT	AVG.	786.58	789.95	655.35	753.59	851.42	751.89	682.39	-1.59
		S.D.	653.31	1231.18	399.76	531.56	1365.77	604.87	619.51	+55.42
07	PERCENT OF CHARGES PAID	AVG.	66.29	74.92	87.03	75.40	73.48	70.38	71.38	-6.35
		S.D.	21.48	19.58	10.26	17.71	18.50	19.61	19.75	+55.45

01 TOTAL DOLLARS PAID	AVG.	41326.26	43268.01	[illegible]					
	S.D.	103160.93	146403.41	45194.15	179875.55	184374.91	188867.92	158899.39	+51.
02 TOTAL NO OF RECIPIENTS SERVED	AVG.	77.26	71.70	33.77	105.92	110.32	112.41	111.60	-9.
	S.D.	154.05	186.77	54.71	186.31	229.21	239.11	237.15	+56.
02 RECIPIENT VOLUME SUMMARY SECTION									
01 NO OF RECIP - MEDICAID ONLY	AVG.	47.13	52.44	32.66	84.38	77.00	78.29	77.01	-3.
	S.D.	86.23	130.62	46.17	148.17	157.73	157.31	153.59	+55.
02 NO OF RECIP - MEDICARE	AVG.	42.04	40.71	15.73	32.84	53.96	55.45	55.04	-18.
	S.D.	86.03	84.28	55.33	68.36	98.29	105.71	106.96	+41.
03 NO OF RECIP - C.C. ONLY	AVG.	5.24	4.80	1.00	6.34	7.18	8.24	9.76	-27.
	S.D.	7.90	14.53	0.00	15.11	16.13	20.83	21.45	+54.
04 NO OF RECIP - C.C. & MEDICAID	AVG.	47.13	51.09	32.66	84.38	77.00	71.30	76.50	-1
	S.D.	86.23	126.22	46.17	148.17	157.73	140.11	150.24	+55
03 FINANCIAL SUMMARY SECTION									
01 TOTAL AMOUNT CHARGED	AVG.	59369.03	57889.84	26754.86	93633.55	90466.37	91715.95	80601.51	-5
	S.D.	134215.48	181727.54	49886.72	210494.80	227826.55	239188.55	202324.56	+56
02 AMT PAID - MEDICAID DIRECT	AVG.	42662.33	45337.95	23900.45	75900.41	67757.40	69393.44	60909.28	-0
	S.D.	103426.32	147586.03	45247.65	180717.08	181458.38	190266.04	158072.15	+56
03 AMT PAID - MEDICARE CROSSOVERS	AVG.	1496.89	1700.64	474.91	1213.09	2106.27	2375.61	2524.93	-22
	S.D.	2443.67	2962.49	1392.37	1637.59	3105.78	3731.58	4435.78	+42
04 AMT PAID - C.C. ONLY	AVG.	6015.86	5357.93	174.00	8063.00	9620.30	8889.73	8807.07	-23
	S.D.	10881.28	17269.83	0.00	19288.69	21984.79	25961.16	20746.36	+53
05 AVG PAYMENT PER PATIENT DAY	AVG.	108.23	105.12	111.66	106.27	107.53	98.70	94.73	-1
	S.D.	37.61	47.64	37.69	35.34	47.75	40.37	36.17	+54
06 AVG PAYMENT PER RECIPIENT	AVG.	786.58	789.95	655.35	753.59	851.42	751.89	682.39	-1
	S.D.	653.31	1231.18	399.76	531.56	1365.77	604.87	619.51	+5[illegible]
07 PERCENT OF CHARGES PAID	AVG.	66.29	74.92	87.03	75.40	73.48	70.38	71.38	-[illegible]
	S.D.	21.48	19.58	10.26	17.71	18.50	19.61	19.75	+5[illegible]
04 ADMISSION - DISCHARGE DATA SECTION									
01 NUMBER OF ADMISSIONS	AVG.	49.23	57.20	30.35	87.18	86.87	84.36	87.85	-7
	S.D.	90.09	141.88	42.23	150.49	173.34	168.56	177.90	+5[illegible]
02 NUMBER OF DISCHARGES	AVG.	50.00	57.43	33.77	90.43	84.78	86.32	85.06	-[illegible]
	S.D.	92.18	143.33	47.66	158.73	174.25	173.54	169.92	+5[illegible]
03 PERCENT DISCHARGES 1 DAY	AVG.	14.14	20.67	13.89	14.30	19.89	13.67	15.61	+[illegible]
	S.D.	15.76	27.87	11.83	18.03	25.33	16.35	20.66	+4[illegible]
04 PERCENT DISCHARGES 2 DAYS	AVG.	19.59	23.43	17.01	19.09	19.11	21.19	21.58	-[illegible]
	S.D.	19.45	23.85	10.48	17.97	17.05	21.81	22.58	+4

MANAGEMENT SUMMARY REPORT: PROVIDER CLASS PROFILES
CATEGORY OF SERVICE: 01
AVERAGES & STANDARD DEVIATIONS SECTION
FOR MONTH OF MARCH, 1975
CLASS GROUP: 00

REPORT ITEM/SECTION NO.	TITLE		CLAIMS PAID THIS MONTH	FOR SVC IN AVG. QTR	FOR SERVICES RENDERED TO DATE AS OF: THIS QTR	1 QTR AGO	2 QTRS AGO	3 QTRS AGO	4 QTRS AGO	TREND RATE
05	PERCENT DISCHARGES 3-5 DAYS	AVG.	42.93	48.35	45.27	42.62	43.53	43.79	41.60	-0.41
		S.D.	21.40	26.75	20.56	20.28	22.40	24.02	21.77	+48.72
06	PERCENT DISCHARGES 6-8 DAYS	AVG.	23.38	26.47	21.93	21.88	23.54	22.12	24.24	-4.82
		S.D.	20.86	23.70	15.13	17.84	20.43	17.49	20.95	+45.22
07	PERCENT DISCHARGES 9-15 DAYS	AVG.	20.72	22.70	19.62	19.11	20.05	22.35	21.25	-5.39
		S.D.	20.02	22.96	15.32	18.84	19.90	21.56	20.34	+45.72
08	PERCENT DISCHARGES 16-30 DAYS	AVG.	10.83	12.50	9.90	9.60	12.92	11.08	10.71	-5.25
		S.D.	14.09	20.10	12.45	13.79	20.51	15.94	14.12	+44.38
09	PERCENT DISCHARGES 31 DAYS UP	AVG.	8.46	8.43	6.32	5.76	10.34	8.30	7.05	+1.40
		S.D.	16.96	21.52	12.07	14.53	23.11	18.57	15.64	+51.87
10	PERCENT DISCHARGES-LTCF	AVG.	7.87	1.50	8.63	3.16	2.87	5.34	3.79	-11.17
		S.D.	8.36	3.24	13.88	3.99	4.30	12.25	5.05	+78.08
11	PERCENT DISCHARGES-HOME HEALTH	AVG.	55.90	31.93	63.89	32.85	70.86	51.34	35.42	-32.90
		S.D.	37.12	35.97	37.58	45.93	42.28	46.63	45.35	+69.63
12	PERCENT DISCHARGES WITH SURG	AVG.	54.26	56.24	50.89	54.14	56.42	54.59	50.90	+1.00
		S.D.	21.93	23.75	20.16	21.13	21.82	22.25	22.29	+43.34
13	PERCENT FRI-SAT ADMISSIONS	AVG.	28.57	36.93	25.28	28.22	29.66	30.38	32.12	-6.09
		S.D.	19.30	28.69	11.29	20.74	22.19	22.96	23.62	+48.00
14	PERCENT SUN-MON DISCHARGES	AVG.	30.98	35.73	27.71	27.65	31.06	28.68	30.12	-3.75
		S.D.	22.36	27.67	17.39	19.24	23.13	21.24	22.00	+47.16
C5	ACCOMMODATIONS SUMMARY DATA SECTION									
01	AVG DAYS STAY PER DISCHARGE	AVG.	8.55	9.10	7.73	7.38	10.05	7.82	8.00	-5.06
		S.D.	9.11	23.87	9.15	6.70	28.01	7.10	9.90	+56.12
02	AVG DAYS PREOP STAY PER DISCG	AVG.	0.31	1.15	0.21	0.27	0.62	1.78	2.10	-64.34
		S.D.	0.44	1.05	0.23	0.57	0.85	2.36	2.09	+27.31
03	PERCENT DAYS-PRIVATE ACCOM	AVG.	12.04	12.17	7.22	8.92	11.61	11.73	10.70	-7.51
		S.D.	22.00	22.06	11.87	16.72	22.42	22.23	21.06	+61.47
04	PERCENT DAYS-SEMIPRIVATE ACCOM	AVG.	89.40	87.89	92.25	90.53	88.50	87.98	90.00	-3.90
		S.D.	16.23	20.00	13.33	13.99	18.56	19.29	17.43	+56.01
05	PERCENT DAYS-WARD ACCOM	AVG.	14.08	15.40	12.57	12.42	16.00	14.78	12.90	-0.48
		S.D.	21.52	27.83	16.66	22.21	27.95	27.13	23.81	+61.97
06	PERCENT DAYS-INTENSIVE CARE	AVG.	5.88	7.19	6.14	4.70	6.25	4.94	5.78	+0.76
		S.D.	11.50	14.58	13.61	10.32	13.49	9.08	12.29	+54.46
07	PERCENT DAYS-CORONARY CARE	AVG.								

	S.D.	9.11	23.87	9.15	6.70	28.01	7.10	8.90	+56.12
02 AVG DAYS PREOP STAY PER DISCG	AVG.	0.31	1.15	0.21	0.27	0.62	1.78	2.10	-64.34
	S.D.	0.44	1.05	0.23	0.57	0.85	2.36	2.09	+27.31
03 PERCENT DAYS-PRIVATE ACCOM	AVG.	12.04	12.17	7.22	8.92	11.61	11.73	10.70	-7.51
	S.D.	22.00	22.06	11.87	16.72	22.42	22.23	21.06	+61.47
04 PERCENT DAYS-SEMIPRIVATE ACCOM	AVG.	89.40	87.89	92.25	90.53	88.50	87.98	90.00	-3.90
	S.D.	16.23	20.00	13.33	13.99	18.56	19.29	17.43	+56.01
05 PERCENT DAYS-WARD ACCOM	AVG.	14.08	15.40	12.57	12.42	16.00	14.78	12.90	-0.48
	S.D.	21.52	27.83	16.66	22.21	27.95	27.13	23.81	+61.97
06 PERCENT DAYS-INTENSIVE CARE	AVG.	5.88	7.19	6.14	4.70	6.25	4.94	5.73	+0.76
	S.D.	11.50	14.58	13.61	10.32	13.49	9.08	12.29	+54.46
07 PERCENT DAYS-CORONARY CARE	AVG.	2.08	2.24	3.60	2.01	2.48	1.83	2.65	+5.21
	S.D.	3.46	8.11	3.84	3.21	9.18	2.29	5.17	+68.00
08 PERCENT DAYS-NURSERY	AVG.	18.96	21.69	20.14	18.02	20.69	18.15	17.83	+1.70
	S.D.	18.58	25.43	16.40	17.25	20.92	21.82	20.25	+40.02
09 AVG ACCOM CHARGE PER DAY	AVG.	66.13	62.57	71.76	65.45	64.26	60.81	59.39	-1.73
	S.D.	26.76	25.27	27.16	25.03	24.40	24.54	24.90	+54.40
10 CHARGES FOR PRIVATE ACCOM	AVG.	1900.09	1861.81	1101.29	2903.92	2993.06	2915.87	2404.01	-4.88
	S.D.	3163.98	3713.11	1701.48	4701.50	5007.45	4845.90	3689.27	+62.10
11 CHARGES FOR SEMIPRIVATE ACCOM	AVG.	18993.20	20792.73	11360.47	33885.76	30589.00	31297.54	28547.27	-1.91
	S.D.	36384.60	51738.06	19348.03	61983.20	62067.71	65525.53	55043.36	+56.54

MANAGEMENT SUMMARY REPORT: PROVIDER CLASS PROFILES
CATEGORY OF SERVICE: 01
AVERAGES & STANDARD DEVIATIONS SECTION
FOR MONTH OF MARCH, 1975
CLASS GROUP: 00

REPORT ITEM/SECTION NO.	TITLE		CLAIMS PAID THIS MONTH	FOR SVC IN AVG. QTR	FOR SERVICES RENDERED TO DATE AS OF: THIS QTR	1 QTR AGO	2 QTRS AGO	3 QTRS AGO	4 QTRS AGO	TREND RATE
12	CHARGES FOR WARD ACCOM	AVG.	2548.63	1821.32	1890.92	3283.06	2721.56	2788.55	3353.32	+2.22
		S.D.	5873.11	4172.17	3075.38	5875.67	5130.37	5647.85	7915.98	+62.08
13	DAYS OF PRIVATE ACCOM	AVG.	26.75	27.90	14.50	41.80	43.49	45.08	37.56	-6.18
		S.D.	42.65	52.80	21.18	65.00	66.09	71.35	56.01	+62.09
14	DAYS OF SEMIPRIVATE ACCOM	AVG.	272.25	318.25	158.99	499.92	461.32	487.60	452.78	-3.51
		S.D.	462.19	705.55	239.88	784.97	830.86	909.77	772.85	+56.33
15	DAYS OF WARD ACCOM	AVG.	36.25	29.59	25.70	53.20	46.82	45.65	51.68	+1.25
		S.D.	62.79	68.90	34.03	93.14	90.93	92.03	93.36	+61.80
16	AVG CHG-PRIVATE ACCOM DAY	AVG.	69.67	64.24	74.27	66.76	67.09	61.50	62.00	-4.65
		S.D.	20.13	20.73	18.04	19.23	20.50	15.91	19.06	+56.30
17	AVG CHG-SEMIPRIVATE ACCOM DAY	AVG.	62.68	58.19	65.46	60.33	59.04	57.52	55.01	-1.96
		S.D.	22.65	22.18	23.95	21.33	20.73	23.28	21.49	+54.58
18	AVG CHG-WARD ACCOM DAY	AVG.	64.48	58.27	65.82	61.08	58.96	58.22	57.75	+2.08
		S.D.	28.74	26.11	26.09	26.68	23.78	23.49	27.25	+55.86

06 ANCILLARY SERVICES SUMMARY DATA SECTION

01 PERCENT CHARGES FOR [illegible]

		[illegible]	27.90	14.50	41.80	43.49	45.08	37.56	-6.18
	S.D.	42.65	52.80	21.18	65.00	66.09	71.35	56.01	+62.09
14 DAYS OF SEMIPRIVATE ACCOM	AVG.	272.25	318.25	158.99	499.92	461.32	487.60	452.78	-3.51
	S.D.	462.19	705.55	239.88	784.97	830.86	909.77	772.85	+56.33
15 DAYS OF WARD ACCOM	AVG.	36.25	29.59	25.70	53.20	46.82	45.65	51.69	+1.25
	S.D.	62.79	68.90	34.03	93.14	90.93	92.03	93.36	+61.80
16 AVG CHG-PRIVATE ACCOM DAY	AVG.	69.67	64.24	74.27	66.76	67.09	61.50	62.00	-4.65
	S.D.	20.13	20.73	18.04	19.23	20.50	15.91	19.06	+56.30
17 AVG CHG-SEMIPRIVATE ACCOM DAY	AVG.	62.68	58.19	65.46	60.33	59.04	57.52	55.01	-1.96
	S.D.	22.65	22.18	23.95	21.33	20.73	23.28	21.49	+54.58
18 AVG CHG-WARD ACCOM DAY	AVG.	64.48	58.27	65.82	61.08	58.96	58.22	57.75	+2.08
	S.D.	28.74	26.11	26.09	26.68	23.78	23.49	27.25	+55.86
06 ANCILLARY SERVICES SUMMARY DATA SECTION									
01 PERCENT CHARGES FOR ANC SVCS	AVG.	45.09	45.97	43.93	45.11	45.52	44.96	44.59	-3.78
	S.D.	12.47	13.65	11.50	12.22	13.95	12.97	13.10	+53.91
02 AVG ANC CHARGE PER DAY	AVG.	57.53	57.78	56.73	55.62	58.91	52.01	50.04	-1.45
	S.D.	32.38	43.30	30.31	32.80	44.11	34.00	33.15	+54.92
03 PERCENT ANC CHGS-OPERATING RM	AVG.	15.43	16.38	15.96	15.61	15.87	15.32	15.88	-0.52
	S.D.	11.36	12.69	11.03	10.49	10.47	10.10	12.03	+44.45
04 PERCENT ANC CHGS-ANESTHESIA	AVG.	4.44	5.62	4.09	4.54	5.44	5.18	5.00	+2.41
	S.D.	5.10	6.40	4.16	5.31	6.65	6.02	6.25	+49.84
05 PERCENT ANC CHGS-DELIVERY ROOM	AVG.	8.45	8.54	10.34	7.81	8.70	8.19	7.34	+3.70
	S.D.	7.65	10.35	8.36	6.95	9.02	10.52	7.93	+38.94
06 PERCENT ANC CHGS-BLOOD ADMIN	AVG.	1.61	1.34	1.51	0.85	1.36	1.68	1.40	-5.22
	S.D.	2.48	2.21	2.17	0.94	1.87	3.80	2.54	+58.21
07 PERCENT ANC CHGS-PHARMACY	AVG.	16.60	16.86	15.14	16.10	16.22	16.82	16.19	-3.15
	S.D.	10.29	10.92	9.12	8.69	10.32	10.21	10.27	+55.01
08 PERCENT ANC CHGS-RADIOLOGY	AVG.	11.46	13.90	11.89	12.69	13.25	13.35	13.64	-4.04
	S.D.	6.90	10.31	7.09	7.93	9.34	9.00	9.92	+52.99
09 PERCENT ANC CHGS-LABORATORY	AVG.	24.91	26.29	25.27	25.44	25.18	24.65	25.95	-2.60
	S.D.	11.39	13.85	10.92	10.83	12.24	11.18	12.51	+54.46
10 PERCENT ANC CHGS-SUPPLIES	AVG.	8.32	8.20	7.97	8.03	8.10	8.52	8.39	-0.90
	S.D.	6.24	7.03	5.51	6.05	6.15	6.87	7.05	+54.83
11 PERCENT ANC CHGS-PHYSICAL TH	AVG.	3.62	3.05	3.65	2.74	3.35	2.97	3.21	-1.69
	S.D.	6.32	6.00	7.32	6.00	6.71	5.86	7.02	+48.63
12 PERCENT ANC CHGS-SPEECH TH	AVG.	1.76	0.75	2.17	1.22	0.43	0.87	0.64	+11.47
	S.D.	2.47	1.43	2.84	2.07	0.47	1.60	1.25	+76.60
13 PERCENT ANC CHGS-INHALATION TH	AVG.	9.02	9.38	9.54	8.31	8.44	8.39	9.51	-9.13
	S.D.	9.19	10.74	9.08	8.83	10.97	8.72	9.52	+48.96
14 PERCENT BLOOD NOT REPLACED	AVG.	94.59	92.09	95.01	94.39	95.12	94.87	92.40	-2.79
	S.D.	16.54	18.54	17.30	15.89	12.96	13.73	17.04	+59.11

Appendix V

SAMPLE STUDY PROJECT PLAN

March 10, 1976

Bureau of Surveillance & Utilization Review

Project Design

Investigation of
MEDICAL SUPPLIES UTILIZATION

Outline

I. The Problem
    a. Source
    b. Definition
II. Project Description
    a. Conceptual Overview
    b. General Plan
III. Purpose
IV. Specific Objectives
V. Methods and Procedures
    a. Things Already Done
    b. Steps in Process
    c. Long-range Agenda
VI. Implementation of Findings
    a. Correction of Abuse
    b. Clarification of Policy
VII. Time Frame
VIII. Staffing

March 10, 1976

Bureau of Surveillance & Utilization Review

Project Design

Investigation of
MEDICAL SUPPLIES UTILIZATION

I. THE PROBLEM

On a single day the Prior Authorization unit of the Bureau of Medical Operations received 46 requests for prior authorizations of medical supplies totaling about $2,450. During the past two months an alarming increase in these requests, particularly for certain uncommon items, has been noted.

Questions raised include:

- Why is the originating physician not signing prescriptions?
- Does the attending "therapist" have proof of his right to call himself a therapist?
- Has the "fitter" been qualified to perform this work by attending school? When? Where?
- How are physical therapy records being maintained?
- Is the "freedom of choice" regulation being violated?
- What are the relationships among the pharmacies, physicians, fitters, and therapists involved in these entangled operations?
- Who is billing for whom in these arrangements?
- Is there conflict of interest?
- Is fraud being practiced in dispensing lower-priced products while billing ODPW for higher-priced items?

Most of this overutilization appears to be concentrated in a couple of facilities and a few individuals associated with them. Because of these recently observed trends and because of the familiar contagion of such practices, it was decided that this tendency toward overutilization of medical supplies should be "nipped in the bud" before abuse becomes widespread.

II. PROJECT DESCRIPTION

Using both S/UR's computerized reporting system and extensive field investigations, answers will be sought to many questions already raised. (See I & V)

A. Field investigations will involve several aspects and levels:
   1. Providers
   2. Recipients
   3. State (legal) Agencies
   4. Professional Consultants

B. Internal processes:
   1. Analyses of computer reports
   2. Study of Prior Authorization requests
   3. Review of Provider Agreements and Handbooks.

C. Possible medical-fiscal audit.

(For details, see V. METHODS AND PROCEDURES).

III. PURPOSE

The purpose of this project embraces five goals:

1. to correct specific instances of overutilization;
2. to eliminate conflict of interest by clarifying fuzzy areas of permissible professional relationships;
3. to develop necessary policy recommendations;
4. to recover any funds fraudulently collected;
5. to pursue possible prosecutions for provider fraud.

IV. SPECIFIC OBJECTIVES

To satisfy the indicated purpose of this investigation, the following specific objectives have been defined:

1. Investigating dramatic increases during the past 2 months in requests for prior authorization of special patterns and other costly equipment by suppliers.
2. Resolving conflict-of-interest issues.
   a. Determining relationships and functions among"therapist," "fitter," "doctor," pharmacies, and medical centers.*
3. Investigating possibly invalid prescriptions at a certain Medical Center.
   a. Probing why prescriptions are not in physician's handwriting.
   b. Checking into how medical records are maintained at these facilities (Preliminary Medical Audit).

(cont'd)

* For purposes of confidentiality and security, names of providers and recipients are not included in general designs and reports. They are incorporated into appendices and made available only to those whose work requires that they have this information.

4. Making specific field checks, through home visits to recipients, on supplies being charged to ODPW.
5. Backing up field investigations with analyses of S/UR computerized data.
6. Guaranteeing freedom of choice to recipients.
7. Developing corrective action to reduce overutilization and inaccurate billing.
8. Recommending needed policy clarifications to appropriate ODPW personnel.

V. METHODS AND PROCEDURES

The basic investigative tool for this study is field inquiry, with on-site visits to both recipients and providers. Findings from these visits and inquiries will be undergirded by analyses of computer data, reviews of claims, evaluations by professional Pharmacy Consultant, and relevant searches into legal relationships.

A. Specifically, the following steps will be pursued in the field*:
   1. Visit a cooperative provider to learn about supplies and equipment:
      a. What they look like (special-pattern corsets, heavy-duty rib-belts, etc.).
      b. What differentiates cheaper from more costly items.
      c. What they are used for.
      d. How long it takes to produce special orders or standard items.
      e. What equipment and skills are required to make them.
      f. How much they should cost.
      g. In what other ways this cooperative provider can furnish technical assistance to this project.
      h. How the testimony this cooperative provider has offered can be used for further legal steps.
   2. Make home visits to 69 recipients to study items with which they have actually been supplied:
      a. To learn what they view as their "condition."
      b. To inquire what use has been made of the supplies.
      c. To compare prices recipients have paid for duplicates of items for which ODPW has been billed.
      (Note: Records of home visits will be part of the interim reports expected).
   3. Visit providers' offices, pharmacies, and suppliers' establishments to check:
      a. Medical records.
      b. Doctor's orders.
      c. Provider Agreements, Medicaid Handbooks, etc.
   4. Visit suppliers under investigation to determine:
      a. What kind of fitting room is in use (washroom, as reported?).
      b. Where medical records are kept. (Or if they are kept?)
      c. Where supplies are kept.

(cont'd)

* Interim reports at various stages of this investigation are expected of responsible staff.

5. Check Secretary of State about corporation papers for these providers.
6. Find evidence of right of "therapist" to this title and practice.
7. Seek proof that "fitter" attended accredited school to qualify as fitter.

B. In-house activities will include:
1. Preliminary analyses of providers as shown in S/UR reports, with reviews of Management Summary Profile Reports, Category 32, Class Group 02.
2. Assessment of findings of preliminary analyses.
3. Further study of Prior Authorization requests.
4. Obtaining from Provider Enrollment Unit copies of Provider Agreements signed by these providers.
5. Listing names and addresses of all recipients who will be contacted, and keeping proper records in process.
6. Pursuing deeper analyses as needed.
7. When Detail Reports have been studied, additional providers may be incorporated into the study.

C. A medical-fiscal audit will be undertaken if analyses-in-depth warrant further investigation at the facilities in question.

D. Submission for review to appropriate ODPW personnel:
1. Supervisor
2. Bureau Chief
3. Pharmacy Consultant
4. Division Chief

VI. IMPLEMENTATION OF FINDINGS

When evaluations of utilization and possible abuses have been completed, recommendations will be made to suitable levels of authority for:

- potential savings
- correction of misuse
- more effective usage
- modifications of policy and procedures, as needed.

These may include the following actions and personnel:

A. For correction of provider abuse:
1. Imposition of restrictions on Prior Authorizations.
2. Auditing processes to establish financial obligations.
3. Institution of legal and/or fiscal measures to reclaim overpaid funds.

B. For elaboration of policy and regulations, recommendations to:
1. Division of Medical Assistance
   a. Division Chief
   b. Chief, Bureau of Medical Program Development (Handbook policy)
   c. Chief, Bureau of Medical Operations.
2. Division of Data Services, Chief
3. Director of District Operations
4. Director of ODPW

(cont'd)

C. For dissemination, once approved by above decision-makers, through all operative levels of ODPW affected:
   1. Pharmacy Consultants
   2. Bureaus processing claims for payment
   3. Provider Assistance Units
   4. Computer programming units
   5. District Offices
   6. County Welfare Departments

VII. TIME FRAME

This project was launched the first of March 1976, and some exploratory steps had been initiated by the time the project was formally designed. It is scheduled to be completed by April 30, 1976.

VIII. STAFFING

This project is carried out under the general direction of Roger W. Brown, Chief of S/UR, and the supervision of Marjorie G. Kelley. It is coordinated by Program Analysts Bernice Koski and Charles Robinson. Program Specialist Paul Cook is assisting with visits to recipients, and Virginia Stewart and Millicent Miketa of the Prior Authorization Unit, Bureau of Medical Operations, are cooperating by referring questionable cases for investigation. Pharmacy Consultant Robert Reid will provide professional expertise in evaluating providers' practices and claims. Unless the project expands unexpectedly, no need for additional staff is anticipated.

Office of Surveillance & Utilization Review

MEDICAL SUPPLIES STUDY

Items Under Review

Name of Item	Price Rates to Carry
Ankle Brace with Metal Upright	$ 60.00
Bars, Adjustable Height	125.00
Chin and Occipital Cups	125.00
Cervical Collar (firm adjustable)	30.00
Cock up with small plate	60.00
Collar, Four Post	125.00
Dorsal-Lumbar Corset	90.00
Knee Splint (hinged cartilege cap)	60.00
Lateral Static Adjustment	125.00
Leg Splint, Osgood-Schlotter	75.00
Lumbo-sacral Corset (Special pattern)	63.00
O.B. Corset	49.50
Metal Adjust. Walker	22.00
Osgood-Schlotter Brace, Small	60.00
Rib belt	20.00
Rib belt (heavy duty)	35.00
Quad Cane	18.50
Wrist Cock-up Splint, Large	60.00
Wrist Splint, Small	60.00

March 1976

Bureau of Surveillance and Utilization Reviews

MEDICAL SUPPLIES PROJECT

Re Recipient Visits: Things to Look For:
(Supplies Issued by Health Care Pharmacy)

In-house Reviews:

1. Prior Authorizations, Suppliers Form:
   a. Review description of item requested.
   b. Review Practitioner's Diagnosis.
   c. Note cost and Allowable Amount.

2. Get addresses from print-out sheets.

In-field Questions:

1. Ask Recipients if you can see item(s) in question.

2. Get size, make, and patent number of item(s).

3. Find out if item(s) have been and are being used.

4. Find out who fitted the item to the recipient (Doctor or Fitter?)

5. If "special pattern" is indicated on Prior Authorization forms, find out from recipient how long it took to get the items. Did it come "out of a box" or was it "one-of-a-kind"?

6. Ask recipient to fill out Affidavit, with her/his own statement or take it down as dictated, to verify items. Have them sign their statements.

[illegible] Utilization Review

[illegible]

on

[illegible] project

1 Prepare list of recipients to be visited on Recipient Visits Log and print record up to date.

2 Ask [redacted] Medical Center to pull charts for these recipients.

3 Send letter to recipients announcing dates of visits.

4 Review charts at [redacted] Medical Center. Get phone numbers of recipients, if possible.

5. Arrange for Bob Reid (Pharmacy Consultant) to review all worksheets. (All worksheets to be brought up to date first.)

6 Set up conference with providers involved when needed information is available and has been summarized

7 Prepare, with summary, questions that need to be raised with providers at this conference.

Page ____ of ____

March 1976

Reviewer _____ Bureau of Surveillance and Utilization Review

RECIPIENT VISITS LOG

ecipient Name	Address	Tel.	Date(s) Visited	Date Reached	Outcome

Appendix VI

HOSPITAL FIELD INVESTIGATION FORM

HOSPITAL FIELD INVESTIGATION

A. General Administration information

1. Go over "exceptional service list" that developed from our computer printout on claims paid. Inpatient _____
Outpatient _____

2. We would like a copy of last two "Statistic Reports" 1974 _____
1975 _____

3. On outpatient drugs we are asking for copies of actual cost on some items. _____

4. We would like a copy of inpatient pricing schedule for pharmaceuticals.

5. We would like copies of Inpatient rate tables used back to Jan. 1, 1974.

6. On the Emergency room visits inquire if this hospital is currently sending treatment and test information to the recipients own physician.

7. Is this hospital advising us of the 3rd party payments received after they invoice us. (On yearly report). _____

8. Is this hospital advising us of the blood donations received on both inpatient and outpatient service. (On yearly report). _____

9. We want a list of all physicians attending our recipients.

10. Does this hospital have any grants. _____

11. We would like to check over admission and disposition sheets 1974-75.

12. We will be looking at 10 different invoices in detail-determining if the various charges are correct and as on medical records. _____

B. Procedures

1. Admission's

a. Is the Admitting Clerk actually checking the Photo I. D. to determine if the holder of the card is our recipient. _____

_____

b. Does the Admitting Clerk check to determine if Medicaid patients also are entitled to Medicare payments. If so is she billing Medicare. _____

_____

c. How is 3rd party information obtained and recorded for our recipients.

_____

_____

d. How is this hospital encouraging the replace of blood used by a recipient through friends and relatives. _____

_____

2. Service

a. Are the recipient receiving the same type of service as their regular patients. _____

_____

b. The procedure and policy used to determine the type and amount of service given for a recipient. In some cases we suspect the recipients are receiving unnecessary service items not given to regular patients.

_____

_____

c. The policy and procedure used when a physician refers one of our recipients to the hospital for tests, x-rays, etc. (We suspect some hospitals are charging us emergency visit codes for this service rather then clinic codes. _____

_____

d. Are the physicians attending the outpatient emergency rooms under contract for this service or are they House physicians. _____

_____

e. The procedure used to dispense drugs are they issuing prescriptions or is the physician giving the drugs directly to the patient. _____

_____

3. Invoicing

a. Is this clerk filling in Section 8 - showing "payment sources, other than Medicaid". _____

_____

b. What method is used to keep tract of blood replaced and give us credit for this. _____

_____

c. How are non-covered services located and put in non-covered column.

_____

_____

Psychiatry

% of Bed Utilization
Weekend leaves (1) Care Room and ancillaries charged
(2) Does psychiatrist continue charge

Intensive Care

% of Bed Utilization
(1) Who determines length of stay in this room, physician or UR committee
(2) Ancillary charges considerably higher in this setting

Laboratory
X-ray - Radiology

procedures ordered
(1) Compare Medicare reports - CPA reports Medicaid against S/UR reports
(2) Both outpatient and inpatient referrals

Outpatient Business Arrangement

(1) Does hospital contract this unit or did hospital set up separate corporation
(2) How is this unit staffed
(3) Does hospital provide the technicians to do lab & x-ray for this unit. How are costs defrayed
(4) Who takes possession of records on lab and x-ray etc.
(5) Does patients physicians receive copy of the records. When and what are lines of communications between patient-outpatient staff and patient family physician or pharmacist.

Other Services

(1) Are recipients receiving the same type of service as their regular patients
(2) What is the procedure and policy used to determine the type and amount of service given for a recipient. In some cases we suspect the recipients are receiving unnecessary service items not given to regular patients
(3) The policy and procedure used when physician refers one of our recipients to the hospital for tests, x-rays etc. (We suggest some hospitals are charging us emergency visit codes for this service rather than clinic codes).

Invoicing

(1) Is Section 8 (Payment sources other than Medicaid being filled out
(2) Is blood replacement record kept
(3) Check these items against their CPA report to ODPW "Hospital Statement of Reimbursable Costs"

Appendix VII

SUBROGATION ACT

111th GENERAL ASSEMBLY,
REGULAR SESSION,
1975-1976

H. B. No. 707

MMES. FIX-KARMIL-MESSRS. BETTS-BOWERS-MURDOCK-FINAN-WEYAND-T. JAMES-NETZLEY-SPECK-LEHMAN

AN ACT

To enact section 5101.58 of the Revised Code to grant the Department of Public Welfare and county welfare departments the right of subrogation in claims against a third party.

Be it enacted by the General Assembly of the State of Ohio:

Section 1. That section 5101.58 of the Revised Code be enacted to read as follows:

Sec. 5101.58. AN APPLICATION FOR AID TO DEPENDENT CHILDREN UNDER CHAPTER 5107., POOR RELIEF UNDER CHAPTER 5113., OR MEDICAL ASSISTANCE UNDER SECTION 5101.51 OF THE REVISED CODE, GIVES A RIGHT OF SUBROGATION TO THE DEPARTMENT OF PUBLIC WELFARE AND THE DEPARTMENT OF WELFARE OF ANY COUNTY FOR THE LIABILITY OF A THIRD PARTY THE COST OF MEDICAL SERVICES AND CARE ARISING OUT OF INJURY, DISEASE, OR DISABILITY OF AN APPLICANT FOR OR RECIPIENT OF MEDICAL ASSISTANCE, TO THE EXTENT OF ANY PAYMENTS MADE UNDER CHAPTER 5107. OR 5113. OR SECTION 5101.51 OF THE REVISED CODE FOR MEDICAL ASSISTANCE SUBROGATION RIGHTS MAY BE ENFORCED SEPARATELY OR JOINTLY BY THE DEPARTMENT OF PUBLIC WELFARE AND COUNTY DEPARTMENT OF WELFARE.

THE THIRD PARTY BECOMES LIABLE TO THE DEPARTMENT OF PUBLIC WELFARE OR COUNTY DEPARTMENT OF WELFARE AS SOON AS NOTIFIED IN WRITING OF THE VALID CLAIM FOR SUBROGATION UNDER THIS SECTION.

SUBROGATION DOES NOT APPLY TO THAT PORTION OF ANY JUDGMENT, SETTLEMENT, OR COMPROMISE OF A CLAIM, TO THE EXTENT OF ATTORNEYS' FEES, COSTS, AND OTHER EXPENSES INCURRED BY A RECIPIENT OF AID OR MEDICAL ASSISTANCE IN SECURING THE JUDGMENT, SETTLEMENT, OR COMPROMISE, OR TO THE EXTENT OF MEDICAL, SURGICAL, AND HOSPITAL EXPENSES PAID BY SUCH RECIPIENT FROM HIS OWN RESOURCES.

AS USED IN THIS SECTION, "THIRD PARTY" INCLUDES ANY PERSON OR PUBLIC AGENCY THAT IS LIABLE TO PAY ALL OR PART OF THE MEDICAL COST OF INJURY, DISEASE, OR DISABILITY OF AN APPLICANT FOR OR RECIPIENT OF MEDICAL ASSISTANCE. "THE RIGHT OF SUBROGATION GIVEN TO THE DEPARTMENT UNDER THIS SECTION DOES NOT INCLUDE RIGHTS TO SUPPORT FROM ANY OTHER PERSON ASSIGNED TO THE STATE UNDER TITLE IV OF THE SOCIAL SECURITY ACT BUT INCLUDES PAYMENTS MADE BY A THIRD PARTY UNDER CONTRACT WITH A PERSON HAVING A DUTY TO SUPPORT."

Appendix VIII

SSI BENEFITS MEMORANDUM

STATE OF OHIO
JAMES A. RHODES, GOVERNOR
KWEGYIR AGGREY, DIRECTOR
RAYMOND F. McKENNA, ASS'T. DIR.
STATE OFFICE TOWER
32nd FLOOR
30 EAST BROAD STREET
COLUMBUS, OHIO 43215
(614) 466-6282

OHIO DEPARTMENT OF PUBLIC WELFARE

May 26, 1976

PUBLIC ASSISTANCE LETTER NO. 648

TO: ALL PUBLIC ASSISTANCE MANUAL HOLDERS

FROM: KWEGYIR AGGREY, DIRECTOR
OHIO DEPARTMENT OF PUBLIC WELFARE K. Aggrey

SUBJECT:
- CO-OPERATIVE LEAD PROGRAM FOR POTENTIALLY ELIGIBLE DISABLED PERSONS UNDER TITLE XVI (SSI)
- INCREASE IN THE MEDICARE BUY-IN PREMIUM RATE

The Ohio Department of Public Welfare's Third Party Resources Section, in agreement with the Social Security Administration, will be initiating a "leads" program to reach disabled persons potentially eligible for Supplemental Security Income benefits starting May 1, 1976. The AFDC Lead Program will make SSI Referrals to the Social Security Administration of potentially eligible ADC recipients identified from the medical diagnoses which accompany Medicaid billings.

The SSA 1610 (See attached) will be used in the referral process. The face side of the SSA 1610 will be filled out by the Third Party Resources Section, Division of Data Services and forwarded to the appropriate county welfare department when a medical condition has been identified through the Medicaid billing process which would indicate a disabling condition exists.

Upon receipt of the SSA 1610 the county welfare department will contact the client and advise him/her of the potential eligibility for SSI benefits. It is the county welfare department's responsibility to inform the recipient of his right to the choice of receiving benefits under either ADC or SSI and the effect that receipt of SSI payments may have on a family's eligibility for Medicaid, ADC and other assistance programs. The reverse side of the SSA 1610 under item 9 will be signed by the client if he wishes to be referred.

The county welfare department will attach to the signed SSA 1610 copies of DPW 7302 and 2453 as well as any other medical information present in the case record and write in item 5-A on face sheet the ADC grant amount attributed to the person (difference between the ADC grant with the person included and the grant without the person included.) This package will then be sent by the county to the Third Party Resource Section, P.O. Box 2667, Columbus, Ohio, 43216.

County welfare agencies will be notified by the Third Party Resource Unit if the client was found eligible or ineligible for SSI by a forwarded copy of SSA 1610.

Effective Date: May 1, 1976

Inquires to: Appropriate District Office

* * * * * * *

The Department of Health, Education and Welare has announced that the Medicare Buy-In premium rate for the period July 1976 through June 1977 will be $7.20. This premium increase will be reflected in the July Social Security Checks. ODPW pays the Buy-In premium for Medicaid recipients.

Effective Date: July 1, 1976

Inquires to: Appropriate District Office

KA:vb

☆ U.S. GOVERNMENT PRINTING OFFICE 1975—523-053 04717

Form Approved.
OMB No. 72-R0752

SOCIAL SECURITY – PUBLIC ASSISTANCE AGENCY
INFORMATION REQUEST AND REPORT

FOLLOW INSTRUCTIONS ON BACK OF FORM SET

1. IDENTIFICATION INFORMATION

a. WAGE EARNER'S NAME	b. SEX	c. DATE OF BIRTH (Mo., Day, Year)	d. DATE OF DEATH (Mo., Day, Year)	e. SOCIAL SECURITY NO. (If unknown, see instructions)	f. CLAIM SYMBOL
	☐ MALE ☐ FEMALE				

2. TO:

SOCIAL SECURITY ADMINISTRATION
1234 Blank Street
Anytown, Ohio 12345

Fold for window envelope

3. PUBLIC ASSISTANCE CLAIMANT

a. CLAIMANT'S NAME: DOE, JOHN

b. SOCIAL SECURITY NO.: 1 2 3 4 5 6 7 8 9

c. DATE OF BIRTH (Mo. Day, Year): 10/10/69

d. CASE NUMBER: 987-6543210

e. ADDRESS: 9876 Blank Street
Anytown, Ohio 12345

f. TELEPHONE NO.: (614) 237-6543

g. RELATIONSHIP TO WAGE EARNER: son

4. WELFARE REQUEST – The information checked (✓) below is requested from SSA records for claimants in items 3 and 10.

A. ☐ Confirm identification in items 1, 3 and 10.

B. ☐ Type of benefit _____ Amount of Current benefit $ _____ Effective (Mo., Yr.,) _____

C. ☐ Are benefits being paid? _____ If not, reason _____

D. ☐ Show type, amount and effective date of current benefit for each person listed in item 10 on reverse.

E. ☐ Is claimant enrolled for SMIB? _____ . Effective date _____

F. ☒ Other (Explain in remarks) SSI REFERRAL AFDC

5. WELFARE REPORT – The information checked (✓) below *either* reports a change in welfare status which may affect Special Age 72 (Prouty) benefits *or* responds to SSA inquiry made in item 7.

A. ☐ Approved to receive public Grant-in-aid money payment; first month paid (Mo., Yr.,) _____

B. ☐ Grant-in-aid money payment being terminated; last month paid (Mo., Yr.,) Yr.,) _____

C. ☐ Eligible under Title XIX for medical assistance only; effective date (Mo., Yr.,) _____

D. ☐ Not Approved Under Grant-in aid titles E. ☐ Other (Explain in remarks (Over))

6.

a. SIGNATURE OF PERSON PROVIDING INFORMATION	b. TITLE	d. DATE
	c. PHONE NUMBER	

7. SSA Request for Information from Public Assistance Agency

A. ☐ Confirm claimant's status by completing applicable parts of item 5., above

B. ☐ Other – (Explain in remarks (Over))

8. Initiating Agency Authorization

A. ☒ Please return Form to:

Third Party Resources Section
Ohio Department of Public Welfare
P.O. Box 2667
Columbus, Ohio 43216

NAME AND ADDRESS OF AGENCY

Information requested will be used only to determine our claimant's eligibility and will not be disclosed to any other organization or individual.

FOR GENERAL ASSISTANCE CASES:
This agency has on file written authorization from the claimant to obtain this information. Applicable only if such authorization required.

b. SIGNATURE OF AUTHORIZED OFFICIAL: Robert S. Shryock

c. TITLE	d. DATE	e. PHONE NO.
Section Chief	5/1/76	466-3620

SOCIAL SECURITY PUBLIC ASSISTANCE AGENCY
INFORMATION REQUEST AND REPORT
Continuation Sheet

9. REMARKS

I wish to file for benefits under the SSI program administered by the Social Security Administration. I understand that this is not an application but that I will be contacted by the social security office in the near future.

Signed: _____

10. SSA BENEFICIARY DATA REQUESTED BY ITEM 4D ON FRONT OF FORM.

NAME AND SOCIAL SECURITY NUMBER OF BENEFICIARY (1)	DATE OF BIRTH (2)	TYPE OF BENEFIT (3)	AMOUNT OF BENEFIT (4)	EFFECTIVE DATE (5)
SS NO.	(Mo., Day, Year)			
SS NO.	(Mo., Day, Year)			
SS NO.	(Mo., Day, Year)			
SS NO.	(Mo., Day, Year)			
SS NO.	(Mo., Day, Year)			

SOCIAL SECURITY PUBLIC ASSISTANCE AGENCY
INFORMATION REQUEST AND REPORT
Continuation Sheet

9. REMARKS

I wish to file for benefits under the SSI program administered by the Social Security Administration. I understand that this is not an application but that I will be contacted by the social security office in the near future.

Signed: _____

10. SSA BENEFICIARY DATA REQUESTED BY ITEM 4D ON FRONT OF FORM.

NAME AND SOCIAL SECURITY NUMBER OF BENEFICIARY (1)	DATE OF BIRTH (2)	TYPE OF BENEFIT (3)	AMOUNT OF BENEFIT (4)	EFFECTIVE DATE (5)
SS NO.	(Mo., Day, Year)			
SS NO.	(Mo., Day, Year)			
SS NO.	(Mo., Day, Year)			
SS NO.	(Mo., Day, Year)			
SS NO.	(Mo., Day, Year)			

Appendix IX

DATA SECURITY MEMORANDUM

OHIO DEPARTMENT OF PUBLIC WELFARE
DIVISION OF DATA SERVICES

POLICY

OSS-21 (5/72)

SUBJECT: Data Security - Computer Systems Control

DATE: June 14, 1976

NO. : 20.1

1. Purpose - To establish for the Division of Data Services, appropriate guidelines to maintain data security and computer systems controls.

2. Scope - Applies to all managers in this Division.

3. Policy

A. Computer Systems Controls

General requirements for computer systems controls are as follows:

(1) Prevent the accidental destruction of data.

(2) Recovery from the accidental destruction of data.

(3) Recovery from the destruction of data due to catastrophic conditions.

(4) Prevent the unauthorized use of data.

(5) Reduce the possibility of unauthorized persons being added to payroll or eligibility files.

(6) Protect the confidentiality of data in line with Amended Substitute Senate Bill No. 99.

B. Specific Items Requiring Security

(1) Data files such as master claims history, recipient master file and money pay data base.

(2) Printed material such as lists indicating names of recipients.

(3) Computer production libraries, for example, load, source, copy and procedure, as well as our private catalog.

(4) CICS applications and physical terminals.

(5) Program and system documentation.

(6) Microfiche.

C. Existing Security Measures

Measures currently being utilized to provide security and protection include:

(1) Use of tape labels to minimize the chance of processing a wrong tape.

(2) Cataloging data sets to insure the use of the current version of a file.

(3) Maintaining multiple copies of critical files.

(4) Off-site storage of production libraries and catalog.

(5) Requiring a password for source program library changes.

(6) Use of Librarian feature indicating source program changes and dates of change.

(7) Limited access to building in off duty hours by Ohio Building Authority (OBA).

(8) Monitoring of computer use and charges through the weekly utilization time and cost report.

(9) Use of a complex file structure for recipient master file and money pay data base.

D. Specific Areas to Be Reviewed, Improved, and Documented Further if Required

(1) Develop and implement a procedure for off-site storage of critical data files.

(2) Stricter control of source program changes through the use of the project task assignment for all changes and the periodic review of Librarian listings for critical modules by the Group Manager.

(3) Establish a tighter control to prevent the updating of a disk data set by more than one job at a time.

(4) Establish a procedure for the identification and scratching of obsolete disk data sets.

(5) Define the use of control totals and record counts in a system and formalize the procedures for their use.

(6) Establish security measures for CICS and develop a method of journalizing updated records to prevent the loss of an operator's work due to destruction of a data file.

(7) Develop guidelines for outside sources who use our facilities and data files.

(8) Develop audit trails for the updating of critical data files.

(9) More extensive use of test files to minimize the chance of accidental destruction of confidential printed material.

(10) Identify and develop a procedure for the collection and destruction of confidential printed material.

(11) Develop guidelines for the release of data.

(12) Develop programs to use System Management Facilities data to monitor system and data file usage.

(13) Appoint a Security Officer to design, develop, implement and monitor the above and to be responsible for the total Division security.

4. Responsibilities:

Mr. Robert Emery is assigned the responsibility for designing, developing, implementing and monitoring the Data Services Computer Systems Controls. Mr. Emery may assign specific responsibilities in the above areas to a designated assistant in writing.

The following named personnel are assigned responsibility for data in their specific areas:

a. Mr. Marvin Hardenbrook - Medicaid Programs/Systems

b. Mr. Donald Miller - Public Assistance/Social Services Programs/ Systems

c. All Bureau Chiefs and Section Chiefs are responsible for security of documentation in their respective areas.

d. Mr. Richard Shafer - Data Base Manager

William H. Barnett, Chief
Division of Data Services

WHB:ph

CMS LIBRARY
3 8095 00014241 0